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Maternity Care at Public Expense

In Six Counties in New York State

United States Department of Labor
Children's Bureau
Publication No. 267

UNITED STATES DEPARTMENT OF LABOR
Frances Perkins, Secretary
CHILDREN'S BUREAU - Katharine F. Lenroot, Chief

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MATERNITY CARE AT PUBLIC EXPENSE

IN SIX COUNTIES IN NEW YORK STATE

July 1, 1935–June 30, 1936

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Letter of Transmittal

UNITED STATES DEPARTMENT OF LABOR,
CHILDREN'S BUREAU,
Washington, October 1, 1940.

MADAM: I transmit herewith a report of a study of maternity care at public expense in six counties of New York State. Data are included on all maternity patients who received medical or nursing care paid for from public funds during the period July 1, 1935, to June 30, 1936, in these six counties.

The study brings to light considerations of general significance in the provision and administration of maternity care, which should point the way toward constructive developments in the program for maternal and infant health.

The study was made by the Children's Bureau in 1937 in cooperation with the New York State Department of Social Welfare and the State Department of Health. It was planned and supervised by Beatrice Hall, medical social consultant of the Children's Bureau. The report was written by Miss Hall in collaboration with Martha M. Eliot, M. D., Assistant Chief of the Bureau, and Edwin F. Daily, M. D., Director of the Maternal and Child Health Division, who reviewed the findings of the study from the physician's point of view. The field work was done by Beatrice Hall, Marguerite Eisenmann, Stella Perryman, and Edna F. Clark.

Grateful acknowledgment is given to Dr. H. Jackson Davis and Marion Rickert of the New York State Department of Social Welfare; Dr. Elizabeth Gardiner and Marion Sheahan of the New York State Department of Health; and the local welfare and health organizations and the private nursing agencies that assisted in providing the data on which the report is based.

Since this report was prepared conferences have been held with State officials, who have indicated that the recommendations of this study are applicable to the administration of maternity care under the present program.

Respectfully submitted.

KATHARINE F. LENROOT, *Chief.*

Hon. FRANCES PERKINS,
Secretary of Labor.

Foreword

The Children's Bureau undertook this study with the purpose of analyzing, for a limited area and period of time, the extent of prenatal, natal, and postnatal care provided through public funds, and the cost of this care. No attempt was made to evaluate the adequacy or quality of the medical service provided. The findings are limited to the number of patients receiving maternity care at public expense, the result of pregnancy, the place of delivery and attendant, expenditures for maternity care, and the content of the care as expressed in terms of the number of visits and the length of the period during which patients received medical or nursing care in their own homes or in hospitals. In order to give added significance to these findings areas were selected that represent varying community resources and resulting differences in medical-care programs.

Recognized gaps in community services and problems arising out of the administration of medical care were brought to the attention of the investigators during the course of the study by local relief and health administrators. The case records also brought to light some problems of general significance in the provision and administration of maternity care.

In addition to statistical data the report thus includes a number of suggestions and conclusions developed in the course of the survey by those responsible for carrying it out. These conclusions are the product not only of an intensive study of pertinent records but even more, perhaps, of numerous conferences with relief administrators, investigators, welfare officers, county commissioners, public-health nurses, representatives of private nursing and family agencies, health officers, and local physicians.

These conferences also revealed significant problems in relation to the needs and practices of the "medically needy" families—those able to maintain themselves but unable to pay for necessary medical care. Consideration has been given to the problem of providing maternity care for this group in the evaluation of procedures for authorizing care and in the recommendations appearing in this report.

It is hoped that the report, embodying an analysis of several types of experience, will help to point the way to constructive developments in the program for maternal and child health and welfare.

Maternity Care at Public Expense in Six Counties in New York State

Plan and Procedure of the Study

Plans for the study provided for an analysis of the extent of maternity care through public funds in six counties of New York State during a 1-year period, from July 1, 1935, to June 30, 1936.

The Children's Bureau conducted the study in cooperation with the New York State Department of Social Welfare and the New York State Department of Health. The field work was done during a 3-month period by four medical social workers from the Children's Bureau, one of whom supervised the study.

New York State was selected as the locale for the intensive study of maternity care at public expense because that State's relief program had included since 1931 a State-wide plan for medical care in the home. This plan, the product of prolonged experience of a highly developed type with problems of relief and public health, was worked out jointly by the Temporary Emergency Relief Administration (hereafter referred to as TERA) and the State Department of Health, with the aid of special advisory committees from the State medical, dental, and nursing organizations. The Manual of Medical Care, issued by the TERA, which contained the rules and regulations governing medical care provided in the home to recipients of home relief, included a statement of minimum standards for maternity service which emphasized prenatal care.

The Public Welfare Law of the State of New York, passed in 1929 and since amended, contains adequate provision for the continuance of the medical-care program administered by the TERA, after its functions and powers were transferred to the State Department of Social Welfare on July 1, 1937.

This State, which had had 5 years of operating experience with a State-wide program, offered what was thought to be a unique opportunity for study of the extent to which public funds were used to provide maternity care in rural areas and small cities and for consideration of the number of women in need of such care who had been reached by the program administered through public-welfare agencies. It was believed also that the findings of such a study would be helpful in planning extension of facilities for maternity care in other areas.

The statistical material was obtained from official records in local departments of public welfare, from records of hospitals and nursing organizations, and from local registrars of vital statistics. A list of patients receiving maternity care at public expense in each of the counties selected for study was made up by reviewing the receipted bills of public relief agencies for medical, nursing, and hospital care for the period of the study and by checking lists of visits by city physicians and lists of admissions to public hospitals.

A separate schedule was prepared for each patient.[1] Local prenatal and postnatal clinics, hospitals, and nursing organizations were then visited in order to secure data on clinic, hospital, and home care. Birth certificates were checked with local registrars to obtain an accurate count of live births and stillbirths. Additional information was obtained from the case records of public relief agencies.

Lack of detail in the records caused considerable difficulty in the collection of statistical material. Relief agencies and nursing organizations carrying heavy case loads are not always able to keep the type of record found in many private case-working agencies. In some rural areas case records were limited to face sheets and relief cards. Nursing records in one county gave only the total number of prenatal and postnatal visits paid to each patient; it was impossible to learn the dates of these visits. In two districts the available records of the work-relief nurses showed only the total number of visits made, classified as prenatal, postnatal, tuberculosis, and so forth, with no record of the patients to whom the visits were made. Although physicians were requested to include dates of prenatal and postnatal visits when they submitted their bills [2] these dates were often missing, and no estimate could be obtained of the length of time the patient was under care.

Furthermore, in small communities the desire to safeguard medical and social information in many cases affected the type of records maintained. Where relief workers and clients were often personally known to each other, detailed information in public-welfare records might be injurious to the patient, particularly in cases of abortion or venereal disease. Furthermore, a great many relief investigators lacked previous training or experience in social work, and few had the opportunity of consultation with public-health nurses or medical social workers who could interpret medical information with due regard for the social needs of patients and consideration of medical ethics.

Information available in the records was supplemented by personal conferences with relief administrators, district and local health officers,

[1] See appendix for schedule used in the study.

[2] See appendix for Temporary Emergency Relief Administration Form 277: Authorization, Invoice, and Voucher for Professional Services.

nurses, and social workers. These conferences revealed the fact that in many instances services had been given that were not recorded. A considerable number of women, for example, had received prenatal care that was not paid for from public funds from physicians who had treated them in the past when they were able to pay. It was not considered practical to attempt to obtain details concerning free services furnished by private physicians. Such services made no small contribution, however, to the adequacy of the medical care obtained by the relief clients—a contribution not paid for from public funds.

History of Relief and Public-Health Administration in New York State

Some knowledge of the history of relief and public-health administration in the State of New York to 1936 is essential to an understanding of the data presented in succeeding sections of this report. Changes in administration after 1936 are referred to only incidentally. Three-fifths of the counties of New York State (exclusive of the five counties coterminous with the boroughs of New York City) are largely rural and contain at most one city of 10,000 to 50,000 inhabitants.

Relief Administration.

The 57 counties outside the boundaries of New York City are subdivided politically into towns, cities, and villages. Villages have no functions in the administration of relief. Towns and cities administered relief from colonial times under various early poor laws, which were superseded and revised by the Poor Law of 1909.[3] Under all these poor laws almshouse care was emphasized as the basic form of relief. Home relief was infrequently given, and it is generally admitted that it was usually inadequate. In the larger cities private organizations grew up which spent large sums, not only for relief but for prevention of sickness and poverty and for rehabilitation of persons in need. Rural areas, however, for the most part lacked such resources.

The Poor Law made limited provision for medical care for recipients of public relief. Hospitalization was provided chiefly for emergency cases and rarely for confinement care, except in counties maintaining county hospitals. Furthermore, the chief interest of the local official (overseer of the poor) was to keep relief costs at a minimum. The provision for medical care was usually interpreted as applying only to persons already receiving other relief. As a result most of the burden of providing medical care for the poor in rural areas was borne by the local physicians, who gave generously of their time and skill.

At the same time a growing volume of legislation increased the relief responsibilities of the counties and of the State, particularly with reference to child health and welfare. These developments brought about increasing cooperation of the town, county, and State, but the administration of home relief remained a function of the local officials administering the Poor Law.

The Public Welfare Law, which superseded the Poor Law and changed the whole concept of public relief and care, was enacted in

[3] Consolidated Laws 1909, Poor Law.

1929 and went into effect January 1, 1930.[4] The Poor Law had emphasized care in almshouses as the basic form of relief; the Public Welfare Law, as originally enacted, emphasized relief given in the home as basic and limited institutional care to cases in which home care was not practicable. The law made it mandatory for every county to appoint or elect a county commissioner of public welfare, who, in addition to administering the public relief and care for which the county public-welfare district was responsible, was given "general supervision and care of persons in need in the territory over which he has jurisdiction." The law provided that costs of certain types of relief and care, such as care for children away from their parents, care for defective or physically handicapped children and children born out of wedlock, and hospital care, might be charged back to the town or city of settlement, although the administrative responsibility was placed with the county commissioner. Responsibility for the administration of home relief and medical care in the home was placed with the town welfare officers who replaced the overseers of the poor.

In the part of this law concerned with administration emphasis was placed on the preventive and constructive aspects of relief, public-welfare officials being directed to "administer such care and treatment as may restore such persons to a condition of self-support, and further give such services to those liable to become destitute as may prevent the necessity of their becoming public charges." Standards of investigation, supervision, and cooperation with other public and private agencies were established.[5]

Among other provisions the law authorized medical care in their homes and in hospitals for persons who, while ordinarily self-sustaining, were unable to provide themselves with needed medical or hospital care.[6] This was a long step forward, but in practical application the Public Welfare Law did not immediately operate to give a full measure of medical service to those in need of care, because it was administered by the local (town) officials, now designated welfare officers. These officials had replaced the overseers of the poor, but the change in title had not altered their point of view.

The situation in one rural county is described in a report by Dr. J. Warren Bell and Dr. Reginald M. Atwater,[7] which states that in 1931 there was almost no public provision for prenatal care for women unable to pay for this service, despite generous legal provisions for public medical care under the Public Welfare Law effective January 1, 1930. Few women knew of the legal provisions, and routine procedure by

[4] Laws of 1929, ch. 565.

[5] Ibid., secs. 77–80.

[6] Ibid., sec. 83.

[7] Providing Prenatal Care for Necessitous Women in Rural New York County. *Milbank Memorial Fund Quarterly*, Vol. 13, No. 2 (April 1935).

which the county department of health cooperated in bringing cases to the attention of the county department of welfare functioned satisfactorily for less than one-fourth of the applicants, despite valid medical reasons why delay was exceedingly undesirable. The defect appeared to be in the slow response of the welfare officers rather than in the routine itself.

The town welfare officers continued to be appointed by the town boards. They were rarely professional persons; the job was a part-time one for which they were paid according to the amount of work demanded of them. Their compensation varied from $200 or $300 a year to about $1,800 in some of the larger towns. Their bills for relief expenditures and for payment of their own services were audited by the town boards, who were interested in keeping relief costs down rather than in providing adequate relief or medical care.

From November 1931 to July 1, 1937, the administration of relief in the home was profoundly influenced by the fact that State aid to local welfare units was available through the Temporary Emergency Relief Administration, whose functions are considered in detail in a later section. When the functions and powers of this administration, pursuant to law,[8] were transferred to the State Department of Social Welfare on July 1, 1937, the duties of the department had been expanded by amendments to the Public Welfare Law to include supervision of local welfare departments, reimbursement of local welfare costs on a participating basis through the fiscal officer of the county, and establishment of rules, regulations, and policies for local administration of public relief and assistance throughout the State.[9]

A certain provision of this law dealt with veterans' relief, requiring legislative bodies to make appropriation for the care and relief of veterans and their families and to determine the method whereby such funds shall be drawn upon by the veterans' organizations which were authorized to dispense relief, and providing that they may pay employees of the relief committees of such organizations for their services in administering veterans' relief.[10]

State and Local Health Administration.

In New York State health protection has been a responsibility of cities and towns and also of villages. Under early laws [11] each city and village and, later, each town was required to appoint annually a board of health and a physician as health officer.

It was not until after 1900 that every city, town, and village complied with these laws. Because of the number and small size of these

[8] Laws of 1937, ch. 358 (amending Public Welfare Law, sec. 3-i.).
[9] Laws of 1936, chs. 873, 874, art. 1-A.
[10] Laws of 1929, ch. 565, sec. 117.
[11] Laws of 1850, ch. 324; Laws of 1885, ch. 270.

units and the fact that no qualification was required for the position of health officer except that he be a physician (and frequently there is only one practicing physician in a village) the problem of providing adequate health protection has presented even greater difficulties than the administration of relief. Because the individual town and village was too small a unit to support necessary health services, there came about a piecemeal development on a county basis of several health activities such as prevention of tuberculosis, milk control, and public-health nursing. These activities were often developed independently, with no definite administrative relationship among the county, town, and village health authorities. Under special enabling laws, counties might conduct, as uncoordinated and unrelated projects, almost every activity of a modern health program without organizing a county board of health which could through central direction coordinate and develop these activities into a unified program.

Since 1915 it has been possible under the Public Health Law for towns and villages to consolidate into larger health districts.[12] In 1921 the law was amended to enable counties to create boards of health and to conduct health services on a county basis.[13] Counties have been slow to organize health departments, however, and in 1937 there were only five counties maintaining county health departments.

The report of the New York State Health Commission, appointed in 1931 by Governor Franklin D. Roosevelt to study and report upon administrative and legislative aspects of public health in the State, dealt largely with the need for reorganization and improvement of local health machinery and mentioned the inequality of services in various sections because of the unevenness of popular sentiment for health action. This report, published in 1932, states: "There are now in up-State New York 1,212 local health jurisdictions consisting of 4 county, 52 city, 309 village, 698 town, and 149 consolidated (village and town or combination of village and town) boards of health or departments of health * * * Excluding county and city health departments there is a total of 1,156 local health units, with population ranging from less than a hundred to a few thousand persons, and covering areas ranging from 0.1 to more than 400 square miles." [14]

Local health agencies are assisted and stimulated by the various divisions of the State Department of Health through district State health officers, district State nurses, and special demonstration clinic services, particularly in orthopedics and maternal care. Other State departments, such as the departments of education and mental hygiene and many voluntary health organizations, notably the New York State Charities Aid Association, county tuberculosis and public-health

[12] Laws of 1915, ch. 555.

[13] Laws of 1921, ch. 509.

[14] Public Health in New York State, ch. 2. Report of New York State Health Commission, 1932.

committees, and visiting-nurse associations also assist the local health authorities.

Within the State Department of Health, a division of child hygiene, created by statute in 1913, was established in 1914 with responsibility for maternal and child care.[15] In 1922 its responsibilities were extended and its name changed to the Division of Maternity, Infancy, and Child Hygiene.[16] This division undertook to stimulate local communities in the organization and extension of maternity and child-hygiene activities. The Division of Public Health Nursing, also created by the statute of 1913, assisted in many of the maternal and child-hygiene activities of the department. The nurses worked under the direction of the secretary of the department until 1920, when a director was appointed and placed in charge of the division.

Increased funds available under the Federal Maternity and Infancy Act (accepted by New York in 1923) made it possible for the Division of Maternity, Infancy, and Child Hygiene to broaden the scope of its activities.[17] The decade between 1920 and 1930 saw a great increase in services for mothers and children under the State program. During this period the decline in the infant mortality rate for New York State was markedly greater and the decline in the maternal mortality rate slightly greater than for the United States as a whole.

The maternal mortality rate for 1935 was the lowest that had ever been achieved in up-State New York. The report of the Division of Maternity, Infancy, and Child Hygiene for that year attributes the lowering of the maternal mortality rate in large part to the provision for medical care during pregnancy and confinement for women in families on relief.

At the end of November 1937 joint State and county funds were maintaining 5 county health departments employing 66 nurses and were also providing nursing service in 32 other up-State counties with a personnel of 76 nurses. These nurses worked under local committees appointed by the county boards of supervisors, and professional direction of their activities was provided by the district State health officers and district State public-health nurses under the general supervision of the State department. State aid to local communities has been given on a county basis since 1923.

Since 1932 the State Department of Health has expanded its services through the district centers rather than from headquarters. Pediatricians and obstetricians of the staff of the Division of Maternity, Infancy, and Child Hygiene have been assigned to certain of the district offices and have been given responsibility to promote the expansion of maternal and child-health activities in these districts under the

[15] Laws of 1913, ch. 559.
[16] Laws of 1922, ch. 402.
[17] United States, 42 Stat. 224; New York, Laws of 1923, ch. 843.

immediate supervision of the district State health officers. Increased attention has been given to the maternal-health work through more frequent inspection of small maternity hospitals and homes, the establishment of additional clinical services, the expansion of the prenatal-letter service, and the provision of increased county nursing service.

Temporary Emergency Relief Administration.

The Emergency Relief Act of the State of New York became law on September 23, 1931.[18] It created the Temporary Emergency Relief Administration in recognition of the peril to public health and safety occasioned by the emergency during the economic depression.

By the Emergency Relief Act the TERA was given the administration of State aid to localities for relief given in the home and for work relief—a new form of relief. The TERA utilized existing local public-welfare authorities to administer the relief for which the State paid part of the cost. Home relief was defined in the act as including not only shelter, fuel, food, clothing, light, and necessary household supplies but also "medical attendance furnished by a municipal corporation [or a town, where home relief is a town charge], to persons or their dependents in their abode or habitation." [19] In this definition medical attendance is recognized as a necessity of life, along with food, shelter, and fuel.

Supervision of the town welfare officers by the county commissioners is provided for in the section dealing with investigation of home relief:

> *Investigation of home relief.*—In a city public-welfare district the city commissioner shall investigate all cases of home relief. In a county public-welfare district where home relief is a county charge, the county commissioner shall investigate such cases. In a county public-welfare district where home relief is a town charge, the town public-welfare officers shall investigate such cases under the supervision and general direction of the county commissioner.[20]

The act as amended authorized State aid to municipalities or to towns to the extent of 40 percent of expenditures for such home relief and work relief as were approved by the administration during the emergency period. The administration could, in addition to the 40-percent reimbursement, make direct grants to a municipal corporation or town on such conditions as it might prescribe.[21] The administration could authorize city and county commissioners to employ additional personnel whose qualifications were satisfactory to it, determine the number of such employees, and fix their salaries. Part or all of

[18] Laws of 1931, ch. 798.

[19] Ibid., sec. 2. Bracketed words were added by Laws of 1933, ch. 646.

[20] Ibid., sec. 13.

[21] Ibid., sec. 16, as amended by Laws of 1932, ch. 567, and Laws of 1934, ch. 65.

such salaries could be paid from the "discretionary fund." [22] In this way the TERA was able to set standards for personnel and to introduce trained workers into local offices.

Home relief had been the basic form of relief in up-State districts for 2 years before the Emergency Act was passed, but the social standards of the Public Welfare Law had not yet been put into general practice and the traditional concept of poor relief was still a powerful force. The creation of the TERA gave an unusual opportunity to the State to put the standards of the Public Welfare Law into operation through the provision for centralized control and reimbursement dependent upon the maintenance of standards.

The administration from the start determined upon certain principles, among others that relief must be adequate, with consideration to the needs of the individual or family, and that investigation to determine this need was not a desk job. Local administrators were allowed wide latitude in the determination of "adequacy," but the State insisted that each locality administer relief consistently and without favoritism. Where additional personnel in local offices were paid from TERA funds, the final selection of such personnel was made by law the responsibility of the local official, although the qualifications of these workers had to be approved by the administration.

Reimbursement by the State of 40 percent of home-relief and work-relief expenditures continued until the autumn of 1933, when the reimbursement rate for home-relief expenditures was raised to 66⅔ percent and the Federal Civil Works Administration took over work relief. After the demobilization of the CWA on April 1, 1934, the TERA reimbursed local districts from State and Federal funds to the extent of 75 percent of approved expenditures for both home and work relief. Upon the transfer of work relief to the Federal Works Progress Administration in December 1935 reimbursement returned to 40 percent, as specified in the original act.[23]

Medical-Care Program.

The Manual of Medical Care, first issued by the TERA in 1931, listed the regulations for medical care and the schedule of charges on which State reimbursement would be given for all kinds of medical care except costs incident to hospitalization, which remained a local responsibility. Local welfare districts were free to establish their own policies and procedures for medical relief but received reimbursement only for expenditures made according to the rules and regulations of the manual. In some communities costs met entirely from local funds were high. In general, these costs represented the difference be-

[22] Ibid., sec. 19, as amended by Laws of 1936, ch. 822.

[23] Final Report of TERA, Nov. 1, 1931–June 30, 1937, p. 31. Albany, 1937.

tween the maximum set by the TERA and the local rates. For instance, the maximum fee on which reimbursement was calculated was $2 for a home visit; in some communities because of transportation difficulties the local welfare officers sometimes had to pay doctors $10 for a home visit.

The maximum for the physician's services for authorized obstetric care in the home was $25; this included necessary prenatal care, delivery in the home, and postnatal care. This charge was subject to the general restrictions and requirements imposed by the manual and to the specific requirements of regulation 4, which required that prenatal care should, whenever possible, begin at or prior to the fifth month of pregnancy. The maximum rate on which reimbursement was allowed for delivery in the home and necessary postnatal care was $15. Payment for prenatal care might be authorized at a rate not to exceed $1 per visit and a total charge not to exceed $10. The regulations and schedule of charges for obstetric care are given in full in the appendix to this report.

The program for medical, dental, and nursing care was worked out jointly by the TERA and the State Department of Health, with the aid of special advisory committees from the State medical, dental, and nursing organizations. The State organization recommended the appointment of similar professional advisory committees to serve locally in each public-welfare district. In the communities where the administration of medical care was most efficiently provided, these local committees advised commissioners in the administration of the local program and in individual problems of professional policy and practice; they assisted (within certain limits) in the determination of schedules for flat-rate charges; they submitted lists of qualified physicians and dentists who wished to cooperate under the program and checked on the professional qualifications of practitioners licensed to practice in New York State who were not members of the local professional organizations.

The introduction to the Manual of Medical Care stated: "The conservation and maintenance of the public health is a primary function of Government. In the present economic depression, the ingenuity of Federal, State, and local relief officials is being taxed to conserve available public funds and, at the same time, to give adequate relief to those in need." [24]

Medical care in the home, as defined in the manual, includes "medicine, medical supplies, and medical attendance furnished by a municipal corporation or a town, where home relief is a town charge, to persons or their dependents in their abode or habitation whenever

[24] Manual of Medical Care, ch. 1, p. 7. Temporary Emergency Relief Administration, New York. March 1936 edition.

possible and does not include hospital or institutional care. It does not include medical, nursing, or dental services given either 'in the home,' in the office, or in a clinic, where such services are already established in the community and paid for, in whole or in part, from local and/or State funds in accordance with local statutes or charter provisions. The scope of 'medical care' . . . includes: Bedside nursing care, as an adjunct to medical attendance; and emergency dental care . . . . 'Medical care' . . . shall be construed ordinarily to include only necessary care for conditions that cause acute suffering, interfere with earning capacity, endanger life, or threaten some permanent new handicap that is preventable when medical care is sought." [25]

The Public Welfare Law requires public-welfare districts to provide needed care for sick and disabled persons in hospitals maintained by municipalities or in any other hospitals visited, inspected, and supervised by the State Board of Charities, and authorizes these districts to contract with other hospitals to pay such sum for the care of sick persons as might be agreed upon.[26] Under the TERA, local communities continued to bear the entire cost of hospitalization. The Manual of Medical Care emphasized throughout its regulations that care in the home was not to be authorized for the treatment of conditions for which hospital care was desirable.

Item 4 under Obstetrical Care stated that in cases where it was the professional opinion of the attending physician that delivery in the home would be hazardous he should notify the local commissioner of public welfare immediately in order that hospitalization might be authorized in accordance with the provisions of the Public Welfare Law.

The aim of the medical program was stated as "the provision of good medical care at a low cost—to the mutual benefit of the indigent patient, professional attendant, and taxpayer." [27] The manual listed the following objectives: Uniform policy, maintenance of professional standards, more adequate medical care ("the policy adopted shall be to augment and render more adequate, facilities already existing in the community for the provision of medical care by medical, dental, and nursing professions to indigent persons"), and uniform procedure.

The administration recognized the need for professional supervision and advice in administering medical care and received advice and expert assistance from the State Department of Health, which assigned a member of its staff as director of medical care. A Division of Medical Care whose staff included a medical social worker was established to provide additional supervision over medical and related problems met

[25] Ibid., pp. 7–8.
[26] Laws of 1929, ch. 565, sec. 85.
[27] TERA Manual of Medical Care, ch. 1, p. 8.

in the administration of both home relief and work relief. The duties of the staff of this division included making surveys, formulating procedures, advising in exceptional or difficult cases, particularly in cases concerned with the treatment of chronic diseases, promoting professional standards, and suggesting policies for more effective provision of care. The director of medical care also acted as liaison officer in medical problems involving the administration, other State and Federal agencies, State and local professional organizations, and local departments of public welfare and health.

All municipal corporations (cities and counties) and towns where home relief was a town charge were eligible for participation in this medical program to the degree necessary to render more adequate, but not to supplant, existing local services. In those communities where medical care was provided primarily on an individual-fee basis the corporation or town was eligible for reimbursement by the administration for all types of medical care covered in the manual.

Standards of professional care were safeguarded by a provision that only professional personnel licensed or registered to practice their respective professions in the State of New York were authorized to participate in the provision of care. It was recommended that commissioners of public welfare maintain approved lists or files of professional attendants who had agreed in writing to comply with the rules and regulations of the manual and authorize care from these lists alphabetically in rotation for patients who did not choose their own attendant when requesting care. The traditional relationships existing between the patient and his professional attendant were recognized in the regulations, and so far as possible the patient was given his choice of physician. Licensed midwives were authorized to provide obstetric care on a reimbursable basis.

Medical care was restricted to persons who were recipients of home relief or who upon investigation by the welfare officer were found to be eligible for home relief. Patients not meeting this requirement were referred to their family physicians or other attendants for care. This regulation was interpreted in most welfare districts to include the group unable to pay for medical care, although able to provide themselves with the bare essentials of living.

To obtain a comprehensive understanding of this program for medical care, it is necessary to keep in mind the wide variation in local resources, the lack of resources in rural areas, and the policy of the TERA "to augment and render more adequate facilities already existing in the community for the provision of medical care by the medical, dental, and nursing professions to indigent persons." The scope of the program was restricted to supplementation of local facilities and implied continuance of the use of hospitals, clinics, and nurs-

ing services already established in the community and paid for, in whole or in part, from public funds. In view of the lack of such resources in many rural areas, it is not surprising that more than two-fifths of the TERA funds spent for medical care was spent on medical relief in rural areas, which constituted approximately one-sixth of the relief load of the State.

During the 5 years preceding July 1, 1937, there was little change in the scope of the medical-care program but a very definite increase in the adequacy and uniformity of the medical care provided. Beginning in 1933 a State-wide project of bedside nursing was developed in cooperation with the State department of health. This service included assistance to physicians attending deliveries as well as postnatal and other types of bedside care, advice in the home on problems such as diet and prenatal care, interpretation of the physician's orders, home calls to determine whether a physician's services were needed, and supplementation of the work of local clinics and health demonstrations. The State department of health drafted the general plan for the service in each community, developed specific programs, and provided continuous supervision.[28]

A law of 1937 [29] required that, by July 1 of that year, all the functions, powers, and duties of the Temporary Emergency Relief Administration relating to home relief be transferred to the State Department of Social Welfare, and the supervision of such relief then became a responsibility of that department. The same law terminated also the local emergency relief bureaus as of such date, or as of July 1, 1938, if permitted by the State Board of Social Welfare to continue until then; and provided that thereafter local relief should become the responsibility of the public welfare officials as successors to such bureaus. A comprehensive system of State aid for home relief was established in 1936 [30] and reimbursement by the State to cities, counties and towns, where home relief is a town charge, was made subject to approval by the State Department of Social Welfare.

[28] Some idea of the scope of the work carried on under this project in the six counties covered in the study can be gained from table 13 (p. 43).

[29] Laws of 1937, ch. 358 (amending Public Welfare Law, sec. 3-i, and adding sec. 3-j).

[30] Laws of 1936, ch. 873, sec. 3-e (amending Public Welfare Law).

Brief Description of the Six Counties Selected

Since limitations on time and funds made a State-wide study by the Children's Bureau impracticable, it became necessary to select districts that would yield findings of maximum general significance. The six counties chosen were decided on after consultation with officials in the State Departments of Health and Social Welfare. They are located in the central and eastern part of the State, and each has a considerable rural population.[31] One county includes a city of more than 100,000 population in the midst of a rural area; no other city of as much as 50,000 population is included.

Although a substantial percentage of the population in all six counties is rural, the counties chosen represent a variety of economic and social backgrounds. Two of them may be classified as farming counties; one has a considerable industrial as well as a large dairy-farming population. Two counties are in mountainous sections where isolation has resulted in a lack of community contacts which has retarded the development of public-health and other social services. The sixth is definitely suburban in character. Infant and maternal mortality rates differed rather widely among the six counties, as did the amount of economic distress during the year of the study. Data regarding live births, stillbirths, and infant and maternal mortality for the State as a whole and for the counties in which the study was conducted are presented in table 1.[32]

In the selection of the areas for study consideration was given to the Temporary Emergency Relief Administration policy in its medical-care program, which was "to augment and render more adequate, facilities already existing in the community."

The six counties, differing in their community resources and health and welfare programs, were selected to illustrate varying methods of providing medical services with the help of State funds, developed in accordance with local programs already in effect. One county operated almost entirely on a fee system; one county and one city, having

[31] In this study the population figures are based on the United States census of 1930. All persons living in places with less than 10,000 inhabitants are classed as rural.

[32] All births and deaths occurring within the State have been allocated to place of residence for counties, cities, and villages. Births are allocated to the usual place of residence of the mother and deaths, with a few exceptions, to the usual place of residence of the decedent. Births outside the State to resident mothers and deaths of residents recorded in other States have not been included in the figures for counties, cities, and villages. This omission results in a slight error in the figures for some of these minor subdivisions, but the error is too small to be significant.

county and city hospitals, authorized confinement care largely in these hospitals and arranged for home deliveries only in emergencies. One city had a system of salaried city physicians and utilized a private clinic for prenatal care.

TABLE 1.—*Live births, stillbirths, and infant and maternal mortality in six New York counties; 1935–36* [1]

Area	Live births		Stillbirths		Infant deaths		Maternal deaths
	Number	Rate (per 1,000 estimated population)	Number	Rate (per 1,000 live births)	Number	Rate (per 1,000 live births)	
New York State	183,173	13.8	6,821	37.2	8,695	47.5	934
County A	936	14.8	24	25.6	40	42.7	5
Rural	452	16.1	13	28.8	20	44.2	1
Urban	484	13.8	11	22.7	20	41.3	4
County B	587	18.1	17	29.0	32	54.5	6
Rural	336	19.9	9	26.8	17	50.6	3
Urban	251	16.1	8	31.9	15	59.8	3
County C	2,853	14.4	91	31.9	148	51.9	13
Rural	908	14.0	34	37.4	52	57.3	5
Urban	1,945	14.7	57	29.3	96	49.4	8
City I	517	16.6	17	32.9	22	42.6	2
City II	1,428	14.1	40	28.0	74	51.8	6
County D	1,082	13.4	41	37.9	55	50.8	8
Rural	696	13.3	25	35.9	30	43.1	5
Urban	386	13.5	16	41.5	25	64.8	3
County E	556	15.9	24	43.2	34	61.2	5
Rural	283	17.9	14	49.5	19	67.1	2
Urban	273	14.3	10	36.6	15	54.9	3
County F	4,769	13.4	143	30.0	187	39.2	25
Rural	3,403	13.4	98	28.8	131	38.5	19
Urban	1,366	13.3	45	32.9	56	41.0	6

[1] Annual reports of the State Department of Health; numbers averaged for the 2-year period; births and deaths allocated to place of residence.

Brief descriptions of the six counties follow. Additional information regarding the administration of relief, including medical care, and regarding local resources for medical and nursing care is given in the section on Maternity Care in Individual Counties.

County A—
First Farming County.

In this county of 65,000 almost half the population is rural. More than half of the rural family groups live on farms, which comprise about 80 percent of the land, and are engaged chiefly in dairying. There is some quarrying and tobacco raising. The population is predominantly native white, only 13 percent being foreign-born and less than 1 percent, Negro.

Some roads are inaccessible in spring and winter because of rain and

snow. The relief families who were visited with the county nurse occupied small houses badly in need of repair and paint; many obtained their water from a pump outside the house. In one section families were living in huts covered on the outside with tin cans.

Applications for relief were made to the 23 town welfare officers, most of whom had no professional training in social work. General supervision of their work was exercised through the county department of public welfare. The commissioner was assisted by an experienced case supervisor, who was handicapped, however, by pressure of work and lack of clerical assistance. Records at the period of this study were limited to relief cards and face sheets containing identifying data.

Much of the burden of medical care for the marginal group was borne by the local doctors. In the rural areas medical care at public expense was provided on a fee basis in accordance with the provisions of the TERA Manual of Medical Care.

The county seat has a population of about 37,000. This includes some 9,000 families, of whom about two-thirds are native white. A diversified group of industrial enterprises employs a considerable part of the population. Home relief was administered by the department of public welfare under the city commissioner. Medical care at public expense was given by five part-time salaried physicians through care in the home and through a city clinic.

County B—
Second Farming County.

About 80 percent of the acreage of this county is in farm land, and more than half of its 30,000 population is rural. Approximately half of the 16,000 rural residents live on farms. The population of the county is mainly native white, only 6 percent being foreign-born.

Dairy farming is the main occupation. Large crops of vegetables are raised for use in local canning factories. Three large creameries and several canning factories constitute the main industries; the county also contains several corset factories, a bakery concern, a wire mill, bottling and clothing factories, and machine shops. The farms appeared prosperous and well cared for, and the relief load was comparatively light, particularly during the summer months. In 1937 a considerable number of families known to the county and city relief offices received no relief other than medical care and clothing.

The lack of proximity to any large city, the lack of any influx of summer population, the good farm land, and the presence of varied industries tends to the development of a stable, self-maintaining population.

Roads are kept in good condition, and all sections of the county are readily accessible except during occasional heavy snowfalls.

Responsibility for investigation and administration of relief rested largely with the town welfare officers, who were assisted by the case investigators in the county office. Medical care was provided in accordance with the regulations of the Manual of Medical Care. This was the only one of the six counties to maintain a county health department under the direction of a full-time physician with training in public health.

The county seat, with a population of 15,000, had several small factories. The town had a generally prosperous appearance. The city commissioner administered relief. A city physician was employed on a part-time basis, but his services did not include maternity care, which was provided by local physicians on a fee basis and through the county prenatal clinic.

County C—
Industrial and Farming County.

This county of 200,000 population contains one city of about 100,000 inhabitants and another of more than 30,000. Approximately one-third of the population is rural. About two-thirds of the acreage of the county is in farm land, used chiefly for dairying. The industrial population is concentrated chiefly in the two cities and in textile villages surrounding them, where housing conditions were particularly bad.

At the time of the study reduced employment in the mill towns had increased the relief needs. Part of the county borders on a mountain region, where both housing and transportation offer serious problems. In the more isolated areas some families receiving relief lived in shacks and summer camps through very severe winters. Applications for home relief were made to the 26 town welfare officers, who received general supervision through the county department of public welfare. Investigators were assigned by the county office to the welfare districts. Authorizations for hospital care were granted through the medical division of the department of public welfare. During the winter months the investigators were sometimes unable to reach parts of their territory for several weeks because the roads were blocked with snow. During these periods the responsibility for administering relief, including medical care, rested almost entirely with the town welfare officers. Coordination between the work of the relief office and that of the county public-health nurses was being worked out, but the county relief office had not yet succeeded in understanding the individual medical needs of persons receiving relief. Records showed a striking lack of understanding of problems related to illness.

City I.—The smaller city is an industrial center with brass and copper industries predominating. One-sixth of its population is foreign-born. The illiteracy rate is relatively high. Home relief was administered efficiently by the department of public welfare. Medi-

cal care was provided on a fee basis according to the regulations of the Manual of Medical Care.

City II.—The larger city is a rapidly growing industrial and shipping center. More than one-fifth of its population is foreign-born, Italians and Poles predominating. As in the smaller city, the illiteracy rate is relatively high. The textile trades constitute the main industry; there are also foundries, engine and boiler works, and other metal factories. The city is a readily accessible shipping center because of the presence of several railroads.

Home relief in this city was administered by the department of public welfare. Home medical care had been provided for many years by city physicians appointed by the mayor and paid on a part-time basis. During the period of the study 12 such physicians were employed. The salaries of the city physicians were not reimbursable under the TERA, as this system of paying physicians had been in operation for several years before the creation of that agency. The medical division of the department of public welfare authorized all medical care, including hospitalization, for the relief and marginal groups.

County D—
First Mountainous County.

This county is in the Catskill region and has a total population of some 80,000. Its rural population numbers more than 50,000—65 percent of the total population—and has a relatively high illiteracy rate. Eleven percent of the population is foreign-born. Somewhat less than half the acreage of the county is in farms, devoted chiefly to fruit growing, dairying, and poultry raising. Cement works, brickyards, and small manufacturing concerns are scattered through the county. There is considerable summer-resort business. Some of the rural sections are remote and inaccessible. Living conditions there are very poor, but the people tend to be self-maintaining and do not readily make their needs known.

The relief investigators in the office of the county commissioner were, for the most part, local residents with no special training for their work. Private physicians often gave free service and also took considerable initiative in bringing needy cases to the attention of relief officials. Maternity care in the home was provided under the regulations of the Manual of Medical Care.

This county has one city with a population of about 28,000, of whom about 9 percent are foreign-born white and 2 percent Negro. Housing conditions are poor. In this city the relief problem loomed large, partly because of seasonal employment. Relief administration was under the department of public welfare. A trained supervisor was in charge of relief administration, and workers under her direction

also investigated hospital admissions for the group not receiving other relief. Home medical care (except maternity care) was supplied by two physicians on part-time salaries; their services to maternity patients were paid for on a fee basis. During part of the period of the study persons on relief were allowed to have treatment by private physicians who were willing to accept the fees provided under the regulations of the Manual of Medical Care.

County E—
Second Mountainous County.

This county, in the east central part of the State, has a population of less than 35,000 persons, of whom more than half are in one city. The population is predominantly native, only 7 percent being foreign-born. Of a rural population of nearly 16,000 about one-fourth are classified as farm population. The county contains little good farm land, and living conditions are poor. Transportation difficulties are great, especially in the winter months. There is some lumbering and a large summer-tourist business.

Relief administration was supervised by the county commissioner, applications being made to the town welfare officers. The work of the two county investigators was hampered by bad roads and severe winter weather. The commissioner maintained good working relationships with the welfare officers and the county nurses. The county had limited medical resources, and isolation added to the difficulty of educating the people to the use of those available.

This county had no general county hospital and no private clinics or dispensaries. Medical care was provided on a fee basis according to the regulations of the Manual of Medical Care.

In the city, located on the edge of a mountain-resort section, relief was administered in the department of public welfare with a staff consisting of an experienced case supervisor and three investigators. Home medical care for relief families, including maternity care, was provided by a city physician.

County F—
Suburban County.

The sixth county, about 30 minutes by train from a large city, has a population of more than 300,000. Almost three-fourths of the population is classified as rural, but only 13 percent of the acreage is in farm land. The entire area is thickly populated. There are several urban centers of 10,000 to 15,000 inhabitants, and these and numerous smaller villages border closely on one another.

The county contains a number of large estates and a great many homes of prosperous and well-to-do persons. Employment is chiefly in professional or clerical work in the nearby large city and in the building and servicing of local homes and estates. The small farming group is

engaged mainly in truck farming. Employment in all these lines was curtailed greatly by the depression; the building trades suffered particularly, and large numbers of skilled workmen and white-collar workers swelled the relief load, which at one time constituted one-sixth of the population.

Transportation was difficult except by automobile, and the high bus fares greatly hampered the effectiveness of the available prenatal and child-health clinics.

An emergency relief bureau administered home and work relief on a county basis through numerous local offices. The regulations of the Manual of Medical Care were closely followed, and home medical care was provided almost entirely on a reimbursable-fee basis. The staff of the emergency relief bureau included two physicians who supervised medical care.

Clinic facilities provided by public and private agencies were considered by local relief and health workers to be inadequate.

General Findings

Number of Women Studied— Results of Pregnancy.

The number of women for whom maternity care was provided at public expense in the six counties during the year of the study was 1,686. The pregnancies of these women resulted in 1,439 live births (85 percent), 59 stillbirths (4 percent), and 188 abortions (11 percent). Table 2 shows for each county and for the urban and rural sections

TABLE 2.—*Result of pregnancy, place of delivery, and attendant; women receiving maternity care at public expense, by county, year ended June 30, 1936*

Area	Total	Live births						Stillbirths			Abortions (actual or threatened)		
		Total	In hospital	In home				Total	In hospital	In home attended by physician	Total	In hospital	In home
				Total	Attended by physician	Attended by midwife	Attended by other person or no attendant						
Total	1,686	1,439	[1] 856	583	573	8	2	59	[2] 48	11	188	[3] 126	62
County A	102	98	30	68	67		1	1		1	3		3
Rural	28	27	3	24	24			1		1			
Urban	74	71	27	44	43		1				3		3
County B	69	66	31	35	33	2		1	1		2	2	
Rural	37	37	12	25	24	1							
Urban	32	29	19	10	9	1		1	1		2	2	
County C	371	336	264	72	67	5		15	15		20	20	
Rural	93	81	60	21	21			5	5		7	7	
Urban	278	255	204	51	46	5		10	10		13	13	
City I	87	78	31	47	44	3		4	4		5	5	
City II	191	177	173	4	2	2		6	6		8	8	
County D	150	127	57	70	70			5	4	1	18	12	6
Rural	63	53	11	42	42			3	2	1	7	1	6
Urban	87	74	46	28	28			2	2		11	11	
County E	65	62	9	53	52		1	2	1	1	1		1
Rural	44	42	5	37	36		1	1		1	1		1
Urban	21	20	4	16	16			1	1				
County F	929	750	465	285	284	1		35	27	8	144	92	52
Rural	710	584	380	204	203	1		24	20	4	102	68	34
Urban	219	166	85	81	81			11	7	4	42	24	18

[1] Includes 9 women delivered at home with postnatal care in hospital.
[2] Includes 1 woman delivered at home with postnatal care in hospital.
[3] Includes 9 abortions occurring at home with aftercare in hospital.

of each county the number of live births, stillbirths, and abortions that occurred to women receiving maternity care at public expense.

Live births and stillbirths were checked against birth certificates in offices of local registrars of vital statistics. No certificate is required in cases where uterogestation has not advanced to the fifth month. Instructions for registering births in the State of New York follow the rules of statistical practice adopted in 1908 by the Section on Vital Statistics of the American Public Health Association.

Among abortions are included all cases of abortion, spontaneous or induced, in which that diagnosis was recorded either on a hospital record or by the physician in his report of his visit or on the form on which he submitted his bill. In the suburban county (County F), where more than half of the women in the study lived, the percentage of cases reported in which the pregnancy resulted in abortion was 16. In the other five counties the corresponding percentage ranged from 12 to less than 2. The number of abortions in the rural areas, except in County F, was probably understated, because of the desire to safeguard this information, in instances where relatives, friends, or acquaintances of the patients might have access as employees to the records in the relief office.

Place of Delivery and Attendant.

More than 60 percent (1,030) of the women cared for at public expense received hospital care (table 2), although in a few cases the woman was taken to the hospital after the birth or abortion occurred. Thirty-eight percent (646) of the women were attended by physicians in their homes.

The negligible number of cases (8) attended by midwives is worthy of comment in view of the fact that in three of the counties studied a considerable part of the population was foreign-born or first-generation native. Relief workers in these sections reported that they received very few requests for the services of midwives and that these requests came from the older women.[33]

The proportion of deliveries paid for from public funds that took place in the patient's home and the proportion that took place in hospitals in each of the six counties reflect local resources and policies.

This is illustrated by the data for the industrial and farming county (County C). Physicians in the rural sections and in the larger city were generally unwilling to perform home deliveries. The rural sections were served by a hospital, supported entirely by county funds. Care given in this hospital was not charged back to the town in which the patient resided. As a result the town welfare officers, who received applications for relief and medical care, made every effort to send maternity patients to the hospital and authorized home deliveries only in emergen-

[33] A downward trend in the use of midwives' services in the State of New York, exclusive of New York City, is indicated by the fact that in 1916, 16 percent of the births in the State were reported by midwives, whereas in 1935 and 1936 only 1 percent of the births were so reported. See New York State Department of Health report for 1916, vol. 1, p. 291; 1935, vol. 2, p. 22; 1936, vol. 2, p. 22.

cies or in instances where the patient refused hospital care. In the rural sections there were 65 hospital deliveries (live births and stillbirths) and 21 home deliveries.

The larger city also was served by a public hospital and had facilities in several private hospitals as well. Physicians were unwilling to perform home deliveries, and if a patient insisted on being confined at home the local welfare department accepted no responsibility for providing medical care, leaving the woman to make her own arrangements. In this city there were 179 hospital and 4 home deliveries. Of the home deliveries, 2 were emergencies and 2 were paid for by the veterans' relief organization.

In the smaller city, on the other hand, the maternity service of the city hospital had a limited bed capacity, physicians were willing to perform deliveries in the home, and a work-relief nurse was available for delivery and postnatal nursing care. The director of the home-relief bureau had unusual skill in individualizing her clients' needs, and decision as to home or hospital delivery was made upon the physician's recommendation after consideration of the home situation. In this city there were 35 hospital and 47 home deliveries.

Maternal Deaths.

Fourteen deaths occurred among the 1,686 maternity patients studied (table 3). All these deaths occurred in hospitals: Five followed live births, four followed stillbirths, and five followed abortions.

Of the five patients who died after giving birth to live infants, two refused prenatal care offered by visiting nurses, one received care in a prenatal clinic for 1 month prior to delivery, and one received medical care for a period of 7 months; for the fifth woman there was no record of prenatal care at public expense. One of this group gave birth prematurely to twins, both of whom died within 48 hours. The infants born to the other four women survived to leave the hospital, one after 12 weeks' boarding care. One of these four infants (child of a woman who refused prenatal care and was said by the nurse to have a history of tuberculosis and syphilis) died during the first month of life. The death certificate recorded "malnutrition" as the cause of death.

TABLE 3.—*Number of maternal deaths among women receiving maternity care at public expense, by county*

Area	Maternal deaths			
	Total	Pregnancy resulting in—		
		Live birth	Stillbirth	Abortion
Total	14	5	4	5
County B—Rural	1	1		
County C—Urban (City II)	1		1	
County D—Urban	1	1		
County E—Rural	1	1		
County F	10	2	3	5
Rural	6	1	1	4
Urban	4	1	2	1

Among the four patients who died after giving birth to stillborn infants no records of prenatal care by a physician were found in three cases; one of these patients had received two home visits from a nurse. The fourth patient received daily home visits from a physician for 1 week during the month prior to her admission to the hospital.

In none of the five cases in which death occurred after an abortion was there any record of medical care at public expense prior to admission to the hospital.

Proportion of Total Live Births That Occurred to Women Cared for at Public Expense.

A comparison between the percentages of family groups receiving home or work relief [34] in the rural and urban areas of the counties studied and the percentages of live births to women receiving care at public expense during the year of study can be made from table 4. The 14,565 families receiving relief in these six counties constituted 9 percent of the families in the area. The 1,439 live births to women receiving maternity care at public expense constituted 13 percent of the total number of live births in the six counties. In each of the six counties as a whole and in the rural sections and all but one of the urban sections of the five counties where separate data were available on urban and rural relief, the percentages of births to women cared for at public expense were higher than the percentages of family groups on relief. The one exception to this was the city in the second mountainous county (County E). As will be pointed out later, the amount of free maternity care given to the relief group by private physicians in this city exceeded that provided at public expense.

These figures should not be regarded as necessarily implying a higher birth rate in the relief group than in the general population. It was pointed out in the section on the History of Relief and Public-Health Administration that the regulation restricting medical care to persons who were eligible for home relief was in most communities interpreted to include the marginal group of persons unable to pay for medical care although able to provide themselves with the bare essentials of living. Hospitalization for maternity care was provided to a large group of persons who did not receive home or work relief, particularly in the two counties (the industrial and farming and the suburban counties) maintaining general county hospitals. In one of these counties (County C) only 22 of 65 patients delivered in the county hospital were known to the home-relief division. In the

[34] The term "work relief" refers only to projects carried on by TERA and does not include Works Progress Administration projects. Although the census definition of a family is somewhat different from that used by the relief administration, the differences are not so great as to invalidate a comparison of the two groups, provided 1-person families are omitted from the census count.

other (County F), 331 of 492 patients delivered in the hospital were known to the home-relief bureau.

TABLE 4.—*Percentage of total families receiving relief and percentage of total live births to women receiving care at public expense, by county*

Area	Total families [1]	Families receiving relief [2]		Total live births [3]	Live births to women receiving care at public expense	
		Number	Percent		Number	Percent
Total	166,618	14,565	9	10,741	1,439	13
County A	15,327	1,090	7	934	98	10
Rural	7,020	327	5	440	27	6
Urban	8,307	763	9	494	71	14
County B	7,822	369	5	593	66	11
Rural	4,052	190	5	332	37	11
Urban	3,770	179	5	261	29	11
County C	44,335	3,382	8	2,810	336	12
Rural	15,158	759	5	876	81	9
Urban	29,177	2,623	9	1,934	255	13
City I	6,241	683	11	506	78	15
City II	22,936	1,940	8	1,428	177	12
County D	19,418	1,489	8	1,096	127	12
Rural	12,566	788	6	708	53	7
Urban	6,852	701	10	388	74	19
County E	8,407	668	8	569	62	11
Rural	3,849	237	6	291	42	14
Urban	4,558	431	9	278	20	7
County F	71,309	7,567	11	4,739	750	16
Rural	49,793	(4)	(4)	3,388	584	17
Urban	21,516	(4)	(4)	1,351	166	12

[1] According to the 1930 census, exclusive of 1-person families.
[2] See ftn. 34
[3] Actual number of live births registered during the period, allocated to place of residence. Annual reports of the State Department of Health.
[4] Home relief in this area was administered on a county basis, and relief figures are not available for rural and urban areas separately.

These data indicate a clear need for continuance of the provision of medical care to the group not on relief. In formulating any program for medical care at public expense the needs of this group should receive consideration. Attention should also be given to the problem of devising more effective means of locating persons in the marginal group who need care.

Expenditures From Public Funds

Total Expenditures.

Total public-welfare and relief expenditures for maternity care for the 1,686 patients studied were slightly more than $64,000 (tables 5 and 6). Of this amount, approximately $14,800 was paid to local physicians for the treatment of patients on a fee basis. The maximum upon which reimbursement was calculated for medical care in the home was $25 for complete maternity care. If prenatal care was not given, the maximum was $15. In two of the cities studied maternity care was included in the duties of salaried city physicians; the cost of this service has been estimated at $665. Midwives' fees amounted to $90. Expenditures for care in public hospitals constituted the largest item, amounting to $34,200. An item of $14,115

TABLE 5.—*Payment for care in maternity cases, by place of care*

Place of care and payment	Maternity cases					
	Total		In rural areas		In urban areas	
	Number	Payment for care	Number	Payment for care	Number	Payment for care
	Cases paid for from public funds only					
Total	[1] 1,686	$64,235.18	[1] 975	$38,461.19	[1] 711	$25,773.99
Hospital cases	[1] 1,030	$49,984.09	574	$29,454.69	456	$20,529.40
Payment to—						
Public hospital	721	34,206.75	402	20,658.45	319	13,548.30
Private hospital	336	14,115.34	188	8,152.74	148	5,962.60
Physicians on fee basis for care during hospitalization	34	707.00	1	25.00	33	682.00
Physicians on fee basis for prenatal and postnatal care given in home	164	918.00	93	601.50	71	316.50
Nurses	4	37.00	2	17.00	2	20.00
Home cases	[1] 656	$14,251.09	[1] 401	$9,006.50	[1] 255	$5,244.59
Payment to—						
Physicians on fee basis	616	13,164.75	415	8,813.00	201	4,351.75
Salaried physicians [2]	63	665.34			63	665.34
Midwives	7	90.00	2	27.50	5	62.50
Nurses	17	331.00	7	166.00	10	165.00
	Cases paid for from public and private funds					
Total		$6,606.00		$3,238.00		$3,368.00
Estimated cost for clinic visits		1,735.00		603.00		1,132.00
Estimated cost for nursing care		4,871.00		2,635.00		2,236.00

[1] The total number of cases is less than the sum of the detail as more than one kind of care was given in some cases.
[2] Proportion of salary estimated for maternity care.

went for care in private hospitals. These totals include few fees to private physicians for deliveries in hospitals; such fees were not reimbursable under TERA regulations.

TABLE 6.—*Expenditures from public funds for maternity care in hospital cases and home cases, by county* [1]

Area	Expenditures for maternity care				
	Total	Hospital cases		Home cases	
		Amount	Percent	Amount	Percent
Total	$64,235.18	$49,984.09	78	$14,251.09	22
Rural	38,461.19	29,454.69	77	9,006.50	23
Urban	25,773.99	20,529.40	80	5,244.59	20
County A	2,942.24	1,634.90	56	1,307.34	44
Rural	811.25	140.25	17	671.00	83
Urban	2,130.99	1,494.65	70	636.34	30
County B	2,371.39	1,477.89	62	893.50	38
Rural	1,186.19	564.19	48	622.00	52
Urban	1,185.20	913.70	77	271.50	23
County C	13,528.25	11,856.00	88	1,672.25	12
Rural	3,028.80	2,502.80	83	526.00	17
Urban	10,499.45	9,353.20	89	1,146.25	11
City I	2,383.70	1,325.45	56	1,058.25	44
City II	8,115.75	8,027.75	99	88.00	1
County D	4,552.30	2,867.30	63	1,685.00	37
Rural	1,563.30	593.30	38	970.00	62
Urban	2,989.00	2,274.00	76	715.00	24
County E	1,663.30	586.30	35	1,077.00	65
Rural	1,357.80	380.80	28	977.00	72
Urban	305.50	205.50	67	100.00	33
County F	39,177.70	31,561.70	81	7,616.00	19
Rural	30,513.85	25,273.35	83	5,240.50	17
Urban	8,663.85	6,288.35	73	2,375.50	27

[1] In addition $6,606 was expended from public and private funds for clinic visits and nursing care.

The $368 recorded for nursing care was in large part for nursing care in the home authorized at the physician's request and included only a small part of the total value of nursing care received by the 1,686 patients. This care included in the $368 was usually given by practical nurses or household helpers. Professional nursing service was provided largely by public and private nursing agencies already in the communities and by the work-relief nursing project which operated in all six counties during the period of the study. It has been estimated that the amount spent for these services for the 1,686 patients studied totaled $4,871, an amount which is not included in the total of $64,235.

The proportions of total expenditures used for hospitalization and for payments to physicians depended to some extent on certain

aspects of the local situation. When medical care for the relief group was administered by the town welfare officers, as it was in the rural districts, costs to the local community were usually a primary consideration.

This is well illustrated by the situation in the rural section of the industrial and farming county (County C). There the costs of hospitalization provided in the county hospital were borne entirely by the county and were not charged back to the town in which the patient resided. Hospital-delivery costs during the period studied averaged $36.02. This included payments for prenatal care in 6 percent of the cases. On the other hand, the patient could be delivered at home by a physician for a fee of $25 (a charge which included payment for prenatal care presumably from the fifth month of pregnancy). For a home delivery the town bore the cost but was reimbursed by the State to an extent varying from 40 to 75 percent during the period of the study. In such a situation the local welfare officer, who was often a businessman or farmer with little training or experience in social work but with a keen appreciation of the value of a dollar, usually authorized hospital confinements. The taxpayers in the town escaped any direct costs in such cases, although taxpayers in the county as a whole were subjected to a heavier cost. The lack of prenatal care for women delivered in the hospital was a factor that appeared to receive little consideration.

The difference in the point of view of the welfare officer and of the physicians, public-health nurses, and social workers, who gave primary consideration to the needs of the patient, created many difficult situations in the administration of the medical-care program.

The figures in tables 5 and 6 make no distinction between the expenditures for which the local unit was reimbursed under TERA regulations and those which were not reimbursable. It has been pointed out that hospital care was uniformly a local responsibility. In addition, some of the physicians' fees were paid by the local administrative unit. In the first farming county, for example, physicians received payment on a fee basis for hospital deliveries, and these fees did not constitute a reimbursable item. Local veterans' relief organizations frequently made special arrangements with local physicians, involving charges that were not reimbursable.

Average Expenditure From Public Funds for Maternity Care.

Average expenditures from public funds were computed separately for home and for hospital deliveries, according to whether they occurred in the rural, the urban, or the suburban areas. Cases of abortion were excluded from this computation.

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The averages are based on amounts actually spent; the figures are not to be interpreted as representing the full cost of adequate medical and nursing service for either home or hospital maternity care. Nor do the expenditures represent the full cost of the services received. Physicians gave professional service without charge to nearly all the patients delivered in hospitals; and the costs of the supplementary clinic and nursing services referred to previously are not included in the average.

In summary, then, the difference between any two sets of figures (rural compared with urban cases, or hospital compared with home cases) may represent either or both of two factors: (1) Differences in the adequacy of services rendered; and (2) differences in the extent to which the services provided were chargeable to public funds.

In the computation of the average expenditures from public funds for maternity care provided to women delivered of live-born or stillborn infants the following items were included: (1) For hospital deliveries—payments to physicians for prenatal, delivery, and postnatal care, to practical nurses or "home helps" for any home care incident to the confinement, and to hospitals (public and private) for delivery and postnatal care and for care in connection with complications of pregnancy; (2) for home deliveries—payments to physicians and midwives for prenatal, delivery, and postnatal care and to practical nurses. The average expenditures in the five counties taken together and in the suburban county (excluding nursing and clinic care during the prenatal period) were as follows:

	Number of women	*Average expenditure*
Home delivery:		
Rural (5 counties)	152	$24. 51
Urban (5 counties)	149	19. 24
Suburban county	293	24. 18
Hospital delivery:		
Rural (5 counties)	98	40. 96
Urban (5 counties)	314	43. 17
Suburban county	492	53. 41

The fact that the average expenditure for home deliveries in all areas is lower than the $25 fee established for complete maternity care is due to the large number of cases in which prenatal care was not paid for directly from public funds. In some instances this care was given in clinics. Some women did not request a physician's services until delivery was imminent, and payment was therefore made only for delivery and postnatal care ($15). In two of the urban areas maternity care was not paid for on a fee basis but was included in the services of salaried physicians.

The average expenditures for home deliveries in the rural areas of each of the five counties where these figures were available showed

little variation. A wider range of average expenditures for home deliveries was found in the urban areas of these counties, where maternity services were rendered in some instances by physicians paid on a part-time salary basis and where there was less demand upon public-relief funds because of available services already established.

The highest average expenditure for hospital delivery in an urban area was $55.36; this included payment for the services of the physician attending the patient in the hospital.

Average Cost, Including Estimated Cost of Nursing and Clinic Care.

The average costs per maternity patient, including the estimated cost of nursing and clinic care not paid directly from public funds, have been computed for each county. These averages were computed on all cases—live births, stillbirths, and abortions. They show rather wide variations from county to county, reflecting the proportion of patients receiving hospital care and local resources for clinic and nursing service.

As a basis for computing these averages the number of nursing and clinic visits to the maternity patients studied was ascertained. After consideration of the actual costs of this service in agencies where figures were available and after consultation with local and State administrators, the cost of prenatal and postnatal nursing and clinic visits was estimated at $1 per visit. The cost of a delivery-nursing visit was similarly estimated at $8. The figure for clinic visits seems high, but it is thought to be a reasonable estimate in view of the small number of patients served by many of the clinics visited. The total cost of nursing and clinic services for the 1,686 patients studied was estimated at $6,606, of which nursing service accounted for $4,871.

These average costs per case, including estimated costs of nursing and clinic care received, were estimated as follows:

County	*Rural*		*Urban*
A. First farming county	$32. 19		$39. 73
B. Second farming county	34. 87		39. 38
C. Industrial and farming county	35. 25	City I	31. 25
		City II	49. 93
D. First mountainous county	28. 24		36. 22
E. Second mountainous county	34. 15		24. 26

The average cost per case in the suburban county was $45.18.

The lowest average cost in rural areas was found in County D. Because many families were isolated on out-of-the-way roads, the amount of public-health and bedside nursing was limited, and women rarely applied for care early in pregnancy. The highest average cost was found in the large city in County C, where practically all cases were hospitalized and the prenatal-clinic and follow-up nursing services were well organized and adequately staffed.

State and Local Expenditures.

Public expenditures for maternity care were divided between hospitalization costs, which were borne entirely by the local unit, and expenditures for home care, in which the State participated (table 6, p. 28). These costs form a small fraction of the total public expenditures for medical care in the six counties. For the year of the study the total expenditure for medical care in which the State participated was $404,542, of which $14,251 was spent for maternity care. (The suburban county, County F, expended more than $300,000 for medical care in the home, of which $7,616 was spent for maternity care.) For the same period the total cost of hospitalization in the six counties has been estimated at $573,000, of which $49,984 was for hospital care of maternity patients.

The amounts spent for hospitalization of maternity patients were thus greater than amounts spent for medical care in the home. However, in the rural areas of four of the counties a greater percentage of the total expenditure for medical care in maternity cases was spent for home medical care than for hospital care. In each of the urban sections, however, where hospital care of maternity patients was more common, greater percentages were spent for hospital than for home care. If amounts spent are compared, it will be seen from table 6 that in all but one of the counties as a whole, and in each of the urban sections, the costs of hospital care exceeded those of home medical care.

Hospital care for maternity patients was definitely restricted in two urban and two rural districts to cases in which hospitalization was recommended by the physician because of complications of pregnancy. A similar regulation was in force in the urban area of County D during part of the period of the study. In two other rural areas the general practice was home delivery, and it appeared that effort was made by relief administrators to keep hospital costs as low as possible.

In the more remote rural areas, particularly in Counties D and E, some women had not had a physician's services at previous confinements and lacked appreciation of the advantages of medical and hospital care. Instances were reported of women who declined hospital care which had been strongly recommended.

Although no instance of refusal to hospitalize a maternity patient upon a physician's recommendation came to light during the study, the question may be raised whether some of the patients delivered at home might not have been more effectively cared for if hospitalization had been provided. In County A, for instance, where hospitalization was authorized only on the physician's recommendation because of complications of pregnancy, 30 percent of the patients delivered were hospitalized. In County C, City I, where decision as

to home or hospital delivery was based on the medical and social needs of the patient, 43 percent of the women received hospital care. It may be assumed that more detailed knowledge of the patients' needs by relief administrators and increased appreciation by patients of the advantages of medical care will increase the percentage of total expenditures used for hospital care.

The cost of hospital care constitutes a staggering burden for some local administrative units, when borne by them alone, and the findings of this study indicate a need for financial aid from the State to local communities in the provision of this type of service.

Duration and Extent of Care

Prenatal Care.

Tables 7 and 8 and tables 14–19 (pp. 46–64) show for the six counties studied the extent of prenatal medical care supplied from public funds for the 1,498 maternity patients delivered of live-born or still-born infants. Included were the care for which payment was made directly from public funds, either to local physicians on a fee basis or to salaried physicians paid from public funds, and the care given through local clinics supported in some instances by public and private funds and in other cases entirely by private funds.

The tables give the number of months prior to delivery during which care was reported, *not* the period of pregnancy at which prenatal care began. In some counties there was a large proportion of women for whom the extent of care was not reported. It should not be assumed that these women received no prenatal care; a number of them were known to have received care from local physicians who were not paid from public funds for their services.

Of the 1,054 patients in the six counties for whom data on prenatal care were reported, only 38 (less than 4 percent) were known to have received no medical supervision during the prenatal period; 23 of these were in rural areas and 15 in urban areas. But more than one-fourth of the 1,054 patients were under care for only 1 month or less prior to delivery; in this group the percentage was slightly higher for urban than for rural areas.

The figures in these eight tables give no basis for conclusions as to the quality of the medical service furnished, as has been stated. The Manual of Medical Care made specific provision for high quality of medical service. In none of the communities studied, however, was there an adequate system of professional review of physicians' records to see that these provisions were being carried out.

A well-trained public-health nurse working in one of the small cities had observed that, after she had prepared patients carefully for the complete examination which she had been taught was essential, physicians often did not think a complete examination, including urinalysis, Wassermann test (not at that time required by State law), and pelvic measurements, was necessary if the patient felt well.

On the other hand, another public-health nurse in a rural area reported an increasing number of patients referred by local physicians for complete prenatal care. One physician in this county had instituted with his private patients a flat payment for prenatal care and

TABLE 7.—*Number of months of medical care prior to delivery, by place of delivery and attendant*

Area, and number of months of care prior to delivery	Maternity cases								
	Total		Place of delivery and attendant						
			Hospital		Home				
					Total		Attended by physician	Attended by midwife	Attended by other person or no attendant
	Number	Percent distribution	Number	Percent distribution	Number	Percent distribution			
Total	[1] 1,498		[2] 904		594		584	8	2
Report on care	1,054	100	507	100	547	100	540	5	2
Care received	1,016	96	488	96	528	97	523	4	1
5 to 8 months	[3] 160	15	86	17	74	14	71	2	1
2 to 4 months	440	42	211	41	229	42	228	1	
1 month or less	290	27	162	32	128	23	128		
Months not reported	126	12	29	6	97	18	96	1	
No care received	38	4	19	4	19	3	17	1	1
No report on care	444		397		47		44	3	
Rural areas	858		498		360		357	2	1
Report on care	559	100	217	100	342	100	339	2	1
Care received	536	96	210	97	326	95	325	1	
5 to 8 months	83	15	38	18	45	13	45		
2 to 4 months	244	44	92	42	152	44	151	1	
1 month or less	143	25	71	33	72	21	72		
Months not reported	66	12	9	4	57	17	57		
No care received	23	4	7	3	16	5	14	1	1
No report on care	299		281		18		18		
Urban areas	640		406		234		227	6	1
Report on care	495	100	290	100	205	100	201	3	1
Care received	480	97	278	96	202	99	198	3	1
5 to 8 months	[3] 77	15	48	17	29	14	26	2	1
2 to 4 months	196	40	119	41	77	38	77		
1 month or less	147	30	91	31	56	27	56		
Months not reported	60	12	20	7	40	20	39	1	
No care received	15	3	12	4	3	1	3		
No report on care	145		116		29		26	3	

[1] Exclusive of 188 cases resulting in abortion.
[2] Inclusive of 10 cases in which delivery was at home and postnatal care in hospital.
[3] Inclusive of 1 woman who reported 9 months of care.

TABLE 8.—*Number of months of medical care prior to delivery, by county*

Area	Maternity cases							
	Total	Care prior to delivery					No care prior to delivery	No report on care
		Total	5 to 8 months or more	2 to 4 months	1 month or less	Months not reported		
Total	[1]1,498	1,016	160	440	290	126	38	444
County A	99	85	17	42	23	3		14
County B	67	49	2	18	15	14	3	15
County C	351	236	42	95	70	29	13	102
County D	132	99	9	28	25	37	15	18
County E	64	45	2	8	6	29	3	16
County F	785	502	88	249	151	14	4	279

[1] Exclusive of 188 cases resulting in abortion.

delivery in order to encourage them to come to him earlier in pregnancy and to report more regularly. His opinion was that this plan worked successfully.

In one of the cities there was no prenatal clinic. The nurses in the city health department carried on prenatal instruction without active cooperation on the part of the city physician. In another city the relief administrator stated that women were unwilling to attend the prenatal clinic, and the nurse assigned to follow-up work reported a discouraging lack of response. This city had a large foreign population with a relatively high illiteracy rate.

In the rural areas prenatal work was handicapped by transportation difficulties, by limited nursing personnel, and by the failure of women to make their needs known because of a lack of appreciation of the advantages of medical care. The State-aided county nurses learned of a large number of patients through local sources of information. These nurses carried heavy case loads, however, and during the winter months parts of five counties were all but inaccessible because of weather conditions. Younger women were found to be taking some initiative in securing care for themselves, but the older women, who had borne a number of children without medical care until delivery, saw little need for prenatal care. Public-health workers recognized a need in these areas for further educational work through agencies such as women's organizations, newspapers, and home-nursing classes in the public schools.

Another handicap met in providing prenatal care for women in families receiving relief was the reluctance felt by many women to have their pregnancy known until it was obvious. In small communities the welfare officers and investigators were often personally acquainted with the women in need of medical services. Many of the relief investigators were young men to whom the women hesitated to make their needs known.

Women in the self-maintaining group unable to pay for medical care often deferred making application in the hope that their financial situation would improve sufficiently to enable them to pay for their own care. Welfare departments are frequently handicapped in providing medical care to the medically needy by the hesitation of families in that group to apply to an agency associated in their minds with relief and dependency.

The most important factors in the administration of any program for prenatal care are the attitude of the welfare officers and the system through which medical care is authorized. Welfare officers in some of the areas authorized hospital care at confinement, but took the view that prenatal care was the responsibility of the family and that if the family were relieved of all responsibility for medical care the result would be more children brought into the world at the expense of the town. Other officers made definite efforts to educate maternity patients as to the desirability of early care.

Postnatal Care.

Available data on postnatal care are shown in tables 9–11. Among the 887 hospital patients in the six counties for whom data were reported, 37 percent remained in the hospital from 6 to 10 days after delivery, 53 percent remained 11 to 14 days, and 8 percent remained 15 days or more. Less than 3 percent (25 patients) remained less than 6 days. Twelve of these 25 patients were in one city where the average length of stay in the maternity service was stated to be 5 days for ward patients and 7 days for private patients. Home care by local physicians and work-relief nurses was authorized freely in this city. Both home and hospital care were authorized through the director of the home-relief bureau, who worked closely with the superintendent of the city hospital.

Data regarding postnatal care for women delivered at home unfortunately are very incomplete. The forms on which the physicians submitted their bills for payment constituted the chief source of information; these forms often read "for prenatal, delivery, and postnatal care," with no further information. In the two cities where salaried physicians were employed these physicians often made visits to the homes of patients whom they had delivered without reporting to the welfare office.

Among the 388 cases for which data were available (see table 10) 173 (45 percent) of the patients received from 4 to 6 postnatal visits each from the physician, 141 (36 percent) received 7 or more visits, and 74 (19 percent) each received 3 visits or less. About half of this last group were urban residents, but 17 of the urban patients were in a city where the data regarding postnatal care are known to be incomplete.

TABLE 9.—*Number of days of postnatal care in hospital, by county*

Area	Women receiving postnatal care in hospital					
	Total	Number of days				
		1 to 5	6 to 10	11 to 14	15 or more	Not reported
Total	[1] 904	25	327	466	69	17
Rural	498	6	211	233	36	12
Urban	406	19	116	233	33	5
County A	30	2	15	6	6	1
Rural	3	1		1		1
Urban	27	1	15	5	6	
County B	32	1	13	17	1	
Rural	12	1	3	8		
Urban	20		10	9	1	
County C	279	14	32	207	26	
Rural	65	1	11	47	6	
Urban	214	13	21	160	20	
City I	35	12	16	5	2	
City II	179	1	5	155	18	
County D	61	3	26	30		2
Rural	13		3	8		2
Urban	48	3	23	22		
County E	10		2			8
Rural	5		2			3
Urban	5					5
County F	492	5	239	206	36	6
Rural	400	3	192	169	30	6
Urban	92	2	47	37	6	

[1] Inclusive of 10 women delivered at home with postnatal care in hospital.

Table 11 presents the available information concerning the duration of postnatal care received by the patients delivered at home. Among 385 women in the six counties for whom this information was reported, 58 percent (222 patients) were under a physician's care from 6 to 10 days after delivery. About 26 percent (102) received medical care for 11 days or more, and the remaining 16 percent (61) had medical care for less than 6 days.

The Manual of Medical Care stated that authorization for obstetric care should include provision for a final gynecologic examination of the mother approximately 6 weeks after delivery. A negligible number of the bills submitted for payment included the date of this examination. The bills were usually submitted for payment within a week or 10 days after delivery, however, and it was the opinion of relief investigators and nurses that examinations were often given at a later date.

Workers in postnatal clinics expressed discouragement at their lack of success in getting patients to return for the final examination.

TABLE 10.—*Number of postnatal visits by physicians to women delivered at home by physicians paid from public funds, by county*

Area	Women delivered at home by physicians				
	Total	Postnatal visits by physicians			
		3 or less	4 to 6	7 or more	Not reported
Total	[1] 584	74	173	141	196
Rural	357	39	132	86	100
Urban	227	35	41	55	96
County A	68	27	10	8	23
Rural	25	10	5	1	9
Urban	43	17	5	7	14
County B	33	8			25
Rural	24	1			23
Urban	9	7			2
County C	67	14	9	1	43
Rural	21	7	7	1	6
Urban	46	7	2		37
City I	44	6	2		36
City II	2	1			1
County D	71	13	17	9	32
Rural	43	12	15	4	12
Urban	28	1	2	5	20
County E	53	1			52
Rural	37	1			36
Urban	16				16
County F	292	11	137	123	21
Rural	207	8	105	80	14
Urban	85	3	32	43	7

[1] Exclusive of 10 women delivered at home with postnatal care in hospital.

These workers thought that the failure of many patients to return was attributable to their concern with their babies rather than with themselves and to the increased pressure of home duties after the addition of the babies to their households. In clinics where a high percentage of patients returned for the final examination there was evidence of careful and persistent follow-up on the part of the clinic nurses. Few clinics were sufficiently staffed for such a follow-up, however. It appears that this important feature of maternity care needs greater emphasis and attention.

TABLE 11.—*Interval between delivery and last visit of physician following home delivery by physicians paid from public funds, by county*

Area	Women delivered at home by physicians				
	Total	Interval between delivery and last visit of physician following delivery			
		Less than 6 days	6 to 10 days	11 days or more	Not reported
Total	[1] 584	61	222	102	199
Rural	357	33	160	63	101
Urban	227	28	62	39	98
County A	68	21	15	10	22
Rural	25	7	7	3	8
Urban	43	14	8	7	14
County B	33	5	2	----	26
Rural	24	1	----	----	23
Urban	9	4	2	----	3
County C	67	10	8	4	45
Rural	21	3	7	4	7
Urban	46	7	1	----	38
City I	44	6	1	----	37
City II	2	1	----	----	1
County D	71	11	16	11	33
Rural	43	10	14	6	13
Urban	28	1	2	5	20
County E	53	1	----	----	52
Rural	37	1	----	----	36
Urban	16	----	----	----	16
County F	292	13	181	77	21
Rural	207	11	132	50	14
Urban	85	2	49	27	7

[1] Exclusive of 10 women delivered at home with postnatal care in hospital.

Maternity Nursing Care Provided Through Community Agencies.

In an earlier section on State and local health administration (pages 6 to 9) mention was made of the development of health services by local units without the central direction necessary for a coordinated and unified program. Services in local areas were dependent to a great extent on local sentiment and local finances. The policy of the State health department was to stimulate local communities to extend their activities through local organizations. Funds available through the Federal Maternity and Infancy Act from 1922 to 1929 made possible financial assistance to selected communities in obtaining specialized medical and nursing services for prenatal care and general instruction in maternity care but not in paying for medical or nursing care at delivery or in the hospital. In some communities these Federal funds were used to pay part of the salary of nurses, half of whose time was given to maternity service. State aid to local

communities has been given on a county basis in New York State since 1923, and nursing services in many up-State counties have in recent years been financed jointly by the county and the State.

Knowledge of this background and policy is essential to an understanding of the maternity nursing services operating in the six counties studied. One of the farming counties maintained a county health department employing three nurses; this department was supported by State and county funds on a 50–50 basis, and the nurses worked under the direction of the county health officer. In four other counties State-aided county nurses worked under local public-health committees; professional direction of their activities was supplied by the district State health officers and supervising nurses. During the period of the study the work-relief project was operating in all six counties, but in the two farming counties no work-relief nurses were assigned to the rural areas. Visiting-nurse associations financed by local public and private funds employed between 35 and 40 nurses in two counties. In several small cities nurses from boards of health were actively engaged in maternity work. Private organizations supported nurses in five counties. Several towns in two counties made some provision for nursing service through local public funds supplemented by private contributions.

Two large insurance companies supplied nursing care for their policyholders, and through this service gave maternity care to large numbers of the low-income group and to some relief recipients. These companies maintained nursing services (through local nursing organizations paid on a fee basis or through their own representatives) throughout the State, except in the most remote rural areas. State officials said that the extent to which these services were available to families on relief could not be estimated accurately, because relief authorities sometimes failed to clear cases needing nursing care through the resource division of the relief organization to ascertain whether such cases were eligible for nursing service from insurance companies. This procedure would have been difficult and might have resulted in delay in providing service to patients urgently in need of attention. The extent to which the services of these nurses were utilized was also limited by the concealment of insurance resources by some relief recipients.

The work of most of these nursing organizations included both bedside nursing and health supervision. The State-aided county nurses were engaged primarily in public-health activities and gave bedside care only in emergencies or for the purpose of teaching families to give such care. In areas where there was no other agency giving bedside nursing care or where the provision for bedside care was very limited, it necessarily followed that such emergencies and demonstrations to families were frequent and time-consuming. The director of the divi-

sion of public-health nursing in the State Department of Health estimated that 44 percent of the field service of the county nurses was in maternal and child-health activities.

Duties of work-relief nurses included delivery-nursing service at the physician's request. Only one other nursing organization, a privately maintained agency in a small city, provided nursing care at delivery.

Some difficulty was experienced in checking the study schedules for nursing care given by the work-relief nurses. At the beginning of this project no funds were available for record keeping. In some sections visits by these nurses were not entered on the permanent record form used by local agencies. Classified totals of visits paid by the work-relief nurses were available in all areas and are presented in table 12.

TABLE 12.—*Visits by work-relief nurses to all maternity cases and to other cases in the area included in the study, by county*

Area	Number of nurses	Total visits	Type of care given [1]			
			Prenatal	Delivery	Postnatal	Other
Total	45	56,763	2,823	75	3,485	50,380
County A—Urban	5	5,644	322	20	655	4,647
County B—Urban	3	4,844	430	1	134	4,279
County C	9	9,796	629	20	334	8,813
Rural	3	3,859	455	10	176	3,218
Urban	6	5,937	174	10	158	5,595
City I	1	1,748	123	10	85	1,530
City II	5	4,189	51		73	4,065
County D	10	14,995	530	28	481	13,956
Rural	5	7,689	336	26	217	7,110
Urban	5	7,306	194	2	264	6,846
County E—Rural and urban	4	5,602	164	5	183	5,250
County F—Rural	14	15,882	748	1	1,698	13,435

[1] Inclusive of bedside nursing and health supervision.

Nursing care by the work-relief nurses was not restricted to relief families but was extended to families who were able to maintain themselves but unable to pay for necessary medical care. A large part of the nurses' work was concerned with the care of mothers and children, and their service included attendance at 75 home deliveries.

In table 13 are presented the available data concerning the contribution of nursing agencies to the care of maternity patients studied. This represents all visits by nurses paid from public or from public and private funds and includes visits by work-relief nurses. It is recognized that the totals for visits fall short of the actual numbers, particularly with reference to the activities of work-relief nurses. The figures therefore fail to represent the actual nursing service

rendered, but they indicate the importance of the contribution made by such community agencies. The cost of the services, as has been pointed out, was estimated at $4,871.

TABLE 13.—*Number of maternity cases cared for and number of visits by nurses* [1] *to women receiving care at public expense, by county*

Area	Type of care given by nurse							
	Prenatal		Delivery		Postnatal bedside		Postnatal follow-up	
	Cases	Visits	Cases	Visits	Cases	Visits	Cases	Visits
Total	499	1,940	35	35	266	1,117	199	322
Rural	249	1,034	6	6	109	439	77	101
Urban	250	906	29	29	157	678	122	221
County A	24	136	20	20	30	279	4	10
Rural	7	39	1	1	3	33	4	10
Urban	17	97	19	19	27	246	----	----
County B	26	88	----	----	11	17	----	----
Rural	12	51	----	----	10	16	----	----
Urban	14	37	----	----	1	1	----	----
County C	211	705	9	9	129	343	103	195
Rural	41	152	----	----	20	48	5	7
Urban	170	553	9	9	109	295	98	188
City I	43	94	9	9	23	118	----	----
City II	127	459	----	----	86	177	98	188
County D	18	136	5	5	25	168	2	3
Rural	12	77	5	5	17	82	2	3
Urban	6	59	----	----	8	86	----	----
County E	40	168	1	1	13	22	13	18
Rural	26	125	----	----	12	20	----	----
Urban	14	43	1	1	1	2	13	18
County F	180	707	----	----	58	288	77	96
Rural	151	590	----	----	47	240	66	81
Urban	29	117	----	----	11	48	11	15

[1] Includes all nurses, work-relief and other, paid from public and from public and private funds. Excludes nurses paid from private funds only.

Maternity Care in Individual Counties

County A—
First Farming County.

In the rural area medical care in the home at public expense was provided by local physicians on a fee basis. In the urban district care was given by five salaried physicians to patients in their homes and at a clinic. These physicians received $100 a month for part-time services; their salaries were reimbursable under TERA regulations. This system was adopted early in 1935 in an effort to reduce the excessive costs of providing medical care entirely on a fee basis. According to an agreement with the county medical society, physicians received $15 for delivery and postnatal care of hospital patients; these fees were not reimbursable items. Prenatal care was given through the privately financed prenatal clinic of a local private hospital; the patient was transferred at the seventh month to the salaried physician, who delivered the patient at home unless complications were present.

Home deliveries were the rule throughout this county, hospitalization being authorized only on the physician's recommendation because of complications. The prenatal clinic in the city was available to all county residents who could obtain the necessary transportation, and hospital care was available in four private hospitals at a daily rate of $3.50, with extra charges for ambulance, delivery room, and special drugs. Hospital care at public expense for maternity patients was usually provided in the two hospitals located in the city. There was some privately financed free hospital service in one of these hospitals.

One county nurse paid from State and county funds did all types of health work in the rural area. Local physicians were referring increasing numbers of maternity patients to her for prenatal instruction. One town employed a nurse who worked under the supervision of the health officer. No work-relief nurses were assigned to the rural areas, but the department of public welfare authorized care by practical nurses at an agreed daily rate to a greater extent than in the other districts studied. In maternity cases these practical nurses assisted at delivery and remained in the home between 1 and 2 weeks. Five work-relief nurses worked in the city under supervision of the city health department. Some nursing service was provided by insurance companies for their policyholders.

Welfare officers were sometimes reluctant to meet the special needs of their clients, such as proper diets for pregnant women. On the

other hand, one welfare officer found difficulty in persuading women to see the need for medical care during the prenatal period, since they had had other children with no medical care prior to delivery. A local physician reported this attitude among many of his patients.

One case may be given as illustrating relief policies. The family consisted of father, mother, and seven children. The man earned $35 a month as a farmer, and had free rent, a garden, and a car. The mother became pregnant, and the welfare officer refused to authorize medical care, saying that the man was earning enough to pay for his wife's confinement.

Local physicians still carried the burden of medical care for this group and were often paid "in kind," usually receiving the worst of the bargain. One physician received in payment for a confinement case several bushels of very large potatoes, all of which were hollow.

In this county 102 maternity patients received assistance from public funds during the year of the study. As table 4 (p. 26) shows, the live births to women receiving care at public expense included 10 percent of the total live births in the county. This percentage was lower than that in any other county.

Only 30 of the 99 women whose pregnancies resulted in live births and stillbirths were hospitalized. The high percentage of home deliveries (70 percent of the total) and the fact that very little bedside nursing service was available in the rural sections of the county, indicated a need for increased service of this type. This need was met in several cases through the authorization of care by practical nurses. In many cases where no nursing care was provided through public funds investigators and the case supervisor stated that relatives or neighbors had given such care. In rural areas the "good neighbor" contributes to the adequacy of social and health services to a degree unknown in urban centers, a situation which accounts for some of the apparent gaps in rural relief programs.

No maternal deaths occurred among the women receiving maternity care at public expense in this county.

Because it was the general practice in this county to provide maternity care at public expense through home deliveries, State funds were used to a greater extent than in any of the other counties studied with the exception of County E. As table 6 (p. 28) shows, almost half of the total public expenditure for maternity care was devoted to care in the home. In the rural section more than four-fifths of the total was spent for home care.

The estimated average cost per case for medical and nursing care, including clinic and nursing service furnished by agencies not paid directly from public funds, was $32.19 in the rural and $39.73 in the urban sections of the county.

Most of the patients were known to have received some prenatal

care (table 14). In no instance was the physician called to deliver the patient as an emergency, a fact which indicates the effective working relationships of the relief agency, the county nurse, and the physicians. In the rural section, however, one-fourth of the patients for whom care was reported, and in the urban area a slightly larger proportion, received care for 1 month or less prior to delivery.

TABLE 14.—*County A: Number of months of medical care prior to delivery, by place of delivery and attendant; women receiving maternity care at public expense*

Area, and number of months of care prior to delivery	Maternity cases				
	Total	Place of delivery and attendant			
		Hospital	Home		
			Total	Attended by physician	Attended by other person
Total	[1] 99	30	69	68	1
Care received	85	26	59	58	1
5 to 8 months	17	5	12	11	1
2 to 4 months	42	12	30	30	
1 month or less	23	8	15	15	
Months not reported	3	1	2	2	
No report on care received	14	4	10	10	
Rural areas	28	3	25	25	
Care received	21	2	19	19	
5 to 8 months	9	1	8	8	
2 to 4 months	5	1	4	4	
1 month or less	5		5	5	
Months not reported	2		2	2	
No report on care received	7	1	6	6	
Urban areas	71	27	44	43	1
Care received	64	24	40	39	1
5 to 8 months	8	4	4	3	1
2 to 4 months	37	11	26	26	
1 month or less	18	8	10	10	
Months not reported	1	1			
No report on care received	7	3	4	4	

[1] Exclusive of 3 cases resulting in abortion.

It seems likely that the figures in tables 10 and 11, showing the amount of postnatal medical care at home, furnish an understatement of the actual amount of postnatal care given the patients, particularly in the urban section, where five city physicians were employed on a monthly basis. Often the physician, having delivered the patient, returned on his own initiative (rather than as a result of a call from the patient, which would as a matter of routine be recorded in the welfare office) and neglected to report the visit to the welfare office. This explanation is corroborated by the relatively large number of cases in which the amount of care was not reported.

County B—
Second Farming County.

County B was the only one of the six counties which maintained a health department under the direction of a full-time physician with training in public health. Three nurses from this department worked in the rural area, each nurse taking care of all the services within her district. The nurses' duties included both public-health instruction and bedside care. Several clinics were conducted by the county health department at its headquarters in the city—prenatal clinics monthly (with a usual attendance of between 10 and 15 patients), well-baby clinics twice a month, venereal-disease clinics twice a week, tuberculosis clinics monthly, and immunization clinics several times a year.

Hospital care at public expense was available to rural maternity patients in a private hospital at the county seat at an agreed basic rate of $3 a day. This hospital had a capacity of 114 beds, with 12 ward beds and several private rooms for the maternity patients. There was some indication that the welfare officers tried to keep hospital costs at a minimum, and one relief investigator criticized the eagerness of physicians to hospitalize maternity patients. No instances of refusal by relief officials to hospitalize a patient upon a physician's recommendation came to the attention of the study workers, however, and 12 out of 37 rural maternity patients were hospitalized during the period of the study.

The county nurses visited all pregnant women referred to them by the relief office or through community contacts; if patients were unable to obtain private care, the nurses referred them to the prenatal clinic. The nurses assisted mothers in the marginal group in arranging hospitalization and made an effort to pass on to the hospital clinical findings in regard to patients for whom hospital care had been recommended. The nurses assisted at home deliveries only in emergencies.

In the city, hospital confinements were the rule, with prenatal care given through the clinic of the county health department. During most of the year covered by the study two and sometimes three work-relief nurses were assigned to health instruction and bedside care.

The relief commissioner had no previous experience in social work but showed unusual readiness to avail himself of opportunities for advice and help from professional workers and was sincerely interested in his job. The office maintained good relationships with the local hospital and the county health department.

The needs of the marginal group received unusual attention in this city, and the health commissioner and the comptroller at the hospital cooperated in making arrangements for the hospitalization of maternity patients able to pay small amounts toward their care. At the

time of this study they were admitted to the hospital as "service" cases at a rate of $2 a day and later at a flat rate of $25 for a 10-day maternity stay; this rate was permitted at the discretion of the comptroller. The health commissioner notified the comptroller of prospective admissions, and these patients were requested to come to the hospital in advance of admission to complete arrangements for care and for payment of their bills.

In this county 69 maternity patients received maternity care at public expense during the year of the study (table 2, p. 22). As is shown in table 4 (p. 26), the live births occurring to women cared for at public expense included 11 percent of the total live births in the county during the period covered.

Hospital care was arranged for 32 women whose pregnancies resulted in live births or stillbirths, 12 in the rural area and 20 in the city. Nursing care in the home at a daily rate was provided for one patient in the rural section and two in the city at a total public expenditure of $65. The data regarding nursing care from the nurses of the county health department are unfortunately incomplete. It seems certain that in the rural area particularly these nurses furnished an important contribution to the adequacy of maternity care.

The average cost per case for medical and nursing care, including estimated costs for clinic and nursing services from community agencies, was $34.87 in the rural section and $39.38 in the city. The average cost in the rural area was higher than in all but one of the other counties; the cost in the city was also relatively high.

In the rural section two-thirds of the 37 patients confined at public expense were known to have received prenatal care (table 15). Three received no prenatal care, and for 9 women information was not available. The period of time under care was ascertained for 14 patients; 2 of these received care for 1 month or less prior to delivery, 11 received care for 2 to 4 months, and 1 patient was under care for at least 5 months.

In the city four-fifths of the 30 patients confined at public expense received prenatal care (table 15). The period of time during which they were under care was ascertained for 21 patients, of whom 14 received care through the prenatal clinic. Thirteen women received prenatal care during 1 month or less prior to delivery, 7 received from 2 to 4 months' care, and 1 patient was under care for 6 months. It is possible that some of these patients received free care from local physicians prior to their attendance at the clinic or before care was authorized through the department of public welfare. It is probable that the greater average duration of prenatal care in the rural section resulted from the concentration in that area of the home visiting of the county nurses.

TABLE 15.—*County B: Number of months of medical care prior to delivery, by place of delivery and attendant; women receiving maternity care at public expense*

Area, and number of months of care prior to delivery	Maternity cases				
	Total	Place of delivery and attendant			
		Hospital	Home		
			Total	Attended by physician	Attended by midwife
Total	[1] 67	[2] 32	35	33	2
Care received	49	20	29	29	
5 to 8 months	2	1	1	1	
2 to 4 months	18	10	8	8	
1 month or less	15	8	7	7	
Months not reported	14	1	13	13	
No care received	3		3	2	1
No report on care received	15	12	3	2	1
Rural areas	37	12	25	24	1
Care received	25	5	20	20	
5 to 8 months	1		1	1	
2 to 4 months	11	3	8	8	
1 month or less	2	1	1	1	
Months not reported	11	1	10	10	
No care received	3		3	2	1
No report on care received	9	7	2	2	
Urban areas	30	20	10	9	1
Care received	24	15	9	9	
5 to 8 months	1	1			
2 to 4 months	7	7			
1 month or less	13	7	6	6	
Months not reported	3		3	3	
No report on care received	6	5	1		1

[1] Exclusive of 2 cases resulting in abortion.
[2] Inclusive of 1 case in which delivery was at home and postnatal care in hospital.

Of the 12 patients from the rural section who were delivered in hospitals, 1 left the hospital before the sixth day after confinement, 3 received from 6 to 10 days of postnatal care, and 8 received from 11 to 14 days (table 9, p. 38). Of the 20 hospital cases in the city 10 received from 6 to 10 days of postnatal care, 9 received from 11 to 14 days, and 1 patient remained in the hospital for a longer period.

For some deliveries in the rural section it was impossible to ascertain the duration of postnatal care, as dates of the physicians' visits were not available. In the city such information was available for 6 of the 9 home deliveries (table 11, p. 40). In 4 cases postnatal care extended for less than 6 days; 1 patient was under the physician's care for 9 days, and 1, for 10 days.

One patient who received care in this county was an Irish woman, 40 years of age, undergoing her twelfth confinement. Her husband was an expert bricklayer who had formerly earned as much as $72 a week; he had been hospitalized the

previous year for chronic appendicitis and double hernia, had had to give up his regular job, and was dependent on occasional employment.

At the time the woman applied for medical care her husband had had no work for 3 weeks. The only income was $15 a month rent from an apartment over a garage the family owned and the earnings of one of the older boys who had seasonal employment in the cabbage fields. The family lived in a large, sparsely furnished house which the father had built. The patient was a very energetic, capable, happy person, who was an excellent manager and delegated household tasks to each of the children, so that the family lived in an atmosphere of mutual cooperation and devotion.

Since the family owed a large hospital bill, the patient could not be admitted without some guarantee of payment. The department of public welfare authorized hospital care and paid $44 for 13 days' stay. The patient attended the prenatal clinic three times and was delivered in the hospital.

The case investigator stated later that this patient was again pregnant. The family had not received relief in some time, and the mother came to tell the case supervisor that since two of the girls were working they expected to be able to take care of the hospital bills themselves. The patient seemed extremely happy over the prospect of the thirteenth baby.

County C—
Industrial and Farming County.

In line with its relatively large population the industrial and farming county had a larger number of maternity patients aided by public funds—371—than any of the others except the suburban county. Of these patients, 93 were in the rural section and 278 in the two cities (table 2, p. 22). Data for the two cities were tabulated separately because of variations in policies and procedures in granting care.

In the rural area maternity patients were generally delivered in the county hospital, a plan favored by the town welfare officers because hospitalization costs were borne by the county and not charged back to the towns. The hospital had no regular prenatal or postnatal clinic, but it was understood that patients wishing this care might come to the hospital at a specified time each week. The resident physician stated, however, that only one or two patients came in the course of a year; no records were kept of the examinations. A considerable number of patients received prolonged prenatal care in the hospital wards, however, some because of complications of pregnancy and others because of lack of other resources for boarding care.

One prenatal clinic, opened during the period of the study, gave care to 30 women; 9 patients reported also for postnatal examinations. During 1937 the clinic had a usual attendance of 5 or 6 patients; the records showed 14 new patients during the first 7 months of the year. The nurses attributed the limited requests for service to transportation difficulties.

Home deliveries were authorized on a fee basis, according to the rules and regulations of the TERA, in emergencies and in instances

where patients refused hospital care. The patient was permitted to choose her own physician from the few available physicians, some of whom were unwilling to perform home deliveries.

Fully three-quarters of the 86 women who gave birth to live or stillborn infants were hospitalized (table 16, p. 53). Little provision was made for prenatal care aside from the one State-aided prenatal clinic, and the marginal and relief groups did not appear to be acquainted with its importance. Nursing service outside the two cities was provided by four nurses maintained by State and county funds. They gave both health instruction and bedside care, and the prenatal clinic mentioned above was under their direction. During the period of the study two work-relief nurses worked under their supervision.

City I.—In the smaller city (City I) relief policies and procedures were clearly defined, and the department had availed itself of opportunities for training staff workers through the training program of the TERA. Relief was administered efficiently, the clients' problems were individualized, and special needs were recognized and given consideration.

Eight clinics of various types were conducted under city, county, or State auspices. The city hospital provided a limited amount of hospitalization at an agreed rate of $3.50 a day, and the working relationship between the relief and hospital administrations was excellent. The organization of available resources here demonstrated that a public medical-care program could be highly flexible. Prenatal care was given in the city clinic or, if reasonable effort to refer patients there failed, by private physicians on a fee basis. Confinement was either at home or in the city hospital, depending on the medical and social needs of the individual. The city hospital had only 6 ward beds and 8 private rooms for maternity patients, a fact which probably influenced to some extent the period of care for the individual patient. During 1936 the usual stay for ward patients was said by the hospital administrator to be 5 days and for private patients 7 days. In this city 35 of the 82 women whose pregnancies resulted in live births or stillbirths (and all 5 of the women whose pregnancies resulted in abortion) received hospital care (table 2, p. 22).

One work-relief nurse attached to the relief office gave prenatal instruction, bedside care, and assistance at delivery at the physician's request. Two nurses from the city health department gave clinic assistance and did follow-up work. A private nursing organization maintained two nurses who gave care on a fee basis, largely to the marginal group.

City II.—In the larger city (City II) all maternity cases were referred to the city hospital for confinement; there was no provision for home deliveries at public expense; and physicians usually refused to deliver patients in their homes.

The lack of any provision for home deliveries at public expense did not appear to be a serious problem, except in very rare instances. Patients usually went to the hospital without hesitation, although it was stated that when the system was first put into operation they frequently raised objections. Here 179 of the 183 patients were delivered in the hospital.

Weekly prenatal and postnatal clinics were conducted in two health centers by a nursing agency. The work of this agency was outstandingly good from the point of view of relationship with the free dispensary and the department of public welfare; the problems of individual patients received careful consideration; prenatal and postnatal follow-up were effectively carried out and efficiently recorded.

Services of the 12 city physicians to maternity patients were limited to treatment of complications of pregnancy in instances in which the patients were unable to attend prenatal clinics. Medical and dental treatment was available at the free dispensary maintained entirely by city funds.

The local nursing organization also supplied nursing care in the home, and a work-relief project was available for housekeeping service to maternity patients both before and after confinement. This organization provided clinics and employed 17 nurses for public-health instruction and bedside-nursing care. In addition, several work-relief nurses worked under their supervision.

Relief records in the department of public welfare indicated that increased food allowances and extra milk were supplied to families in which women were known to be pregnant. In some active home-relief cases, however, it was noted that no mention of the woman's condition was made until the medical investigator had completed arrangements for hospital care, usually in the ninth month of pregnancy. Requests for medical care, including hospitalization, were handled by a separate division of the department of public welfare, and there was a recognized need for a closer working relationship between the home-relief division and the medical division.

The two workers in the medical division were handicapped by pressure of work, and neither worker had had the experience in public-health or medical social work essential to an understanding of the interrelation of medical and social factors. The lack of such training and experience limited the workers' usefulness in explaining the medical needs of clients to the relief division.

The average cost per case, in county C as in the other counties studied, reflected the amount of hospital care given, being higher in those areas where hospital care was provided freely. In the rural section the average cost, including estimated costs of clinic and nursing care obtained through community agencies, was $35.25. In the larger

TABLE 16.—*County C: Number of months of medical care prior to delivery, by place of delivery and attendant; women receiving maternity care at public expense*

Area, and number of months of care prior to delivery	Maternity cases				
	Total	Place of delivery and attendant			
		Hospital	Home		
			Total	Attended by physician	Attended by midwife
Total	[1] 351	[2] 279	72	67	5
Care received	236	179	57	54	3
5 to 8 months	42	35	7	5	2
2 to 4 months	95	81	14	14	
1 month or less	70	60	10	10	
Months not reported	29	3	26	25	1
No care received	13	10	3	3	
No report on care received	102	90	12	10	2
Rural areas	86	65	21	21	
Care received	35	16	19	19	
5 to 8 months	2		2	2	
2 to 4 months	11	6	5	5	
1 month or less	12	7	5	5	
Months not reported	10	3	7	7	
No care received	1		1	1	
No report on care received	50	49	1	1	
Urban areas	265	214	51	46	5
City I	82	35	47	44	3
Care received	52	18	34	33	1
5 to 8 months	4	1	3	3	
2 to 4 months	13	5	8	8	
1 month or less	16	12	4	4	
Months not reported	19		19	18	1
No care received	3	1	2	2	
No report on care received	27	16	11	9	2
City II	183	179	4	2	2
Care received	149	145	4	2	2
5 to 8 months	36	34	2		2
2 to 4 months	71	70	1	1	
1 month or less	42	41	1	1	
No care received	9	9			
No report on care received	25	25			

[1] Exclusive of 20 cases resulting in abortions.
[2] Inclusive of 3 cases in which delivery was at home and postnatal care in hospital.

city it was higher than in any other community studied—$49.93—and in the smaller city it was $31.25, a relatively low figure.

For this county pertinent data regarding prenatal care in the 351 cases of live births and stillbirths are presented in table 16. It will be seen that in many cases it was impossible to ascertain the extent of this care. In the rural section prenatal care was reported for 35 of the 86 deliveries studied. One welfare officer stated that during the several years he had been in office no woman had ever asked

him to authorize prenatal care. Another welfare officer said he had received such requests but usually refused them, believing that the man could get odd jobs and pay for his wife's care. He went on to say that he did not believe in arranging all this care, because if families were relieved of all financial responsibility they would continue to have children year after year at public expense. Further conversation with relief and health officers gave the impression that the authorizations for prenatal care were not given readily and that the usual practice was to authorize confinement care in the county hospital and assume that the family would be able to obtain prenatal care through its own resources.

Forty-three of the 65 rural patients delivered in the county hospital were not receiving other aid from public funds, and it is possible that some of these patients were able to secure prenatal treatment from private physicians through their own resources. The superintendent of the county hospital stated, however, that a high percentage of the maternity patients entered the hospital as emergency cases, and it was his belief that an equally high percentage had no prenatal care. The district State health officer recognized this lack and was working to meet the need.

In the larger city more than 80 percent of the patients (149 out of 183) were known to have received prenatal care. Of those reporting the length of care received, the percentages receiving care for relatively long periods prior to delivery were larger than in the 6 counties as a whole. As table 16 indicates, 24 percent received care for 5 months or more prior to delivery, and 48 percent received care for periods ranging from 2 to 4 months; on the other hand, 28 percent received care for 1 month or less prior to delivery.

Among the hospital cases the length of hospital stay after delivery varied considerably in the three communities, as is shown in table 9 (p. 38). In the rural section the majority of the patients remained in the hospital from 11 to 14 days, and most of the other patients remained from 6 to 10 days. In the larger city, also, the great majority (155 out of 179) of the patients received from 11 to 14 days of postnatal care in the hospital; 10 percent remained 15 days or longer. In the smaller city, however, 12 out of 35 patients confined in the hospital left before the sixth day, and 16 remained 6 to 10 days.

Tables 10 and 11 (pp. 39–40) show data regarding postnatal visits of physicians to patients delivered at home. In the rural section of County C data on the number of visits were available for 15 of the 21 patients delivered at home. Of these 15 patients, 7 received 3 visits or less from a physician following delivery; 7 received from 4 to 6 visits. Of the 14 patients for whom data were secured regarding the duration of postnatal care 3 received care less than 6 days, 7 received

care for 6 to 10 days, and 4 were under a physician's care for 11 days or more.

In the large city only 4 of the 191 deliveries studied occurred at home; 2 of these were arranged for by the veterans' organization, and 2 were emergency cases. Final gynecologic examinations were received by 62 of the 191 patients. Careful follow-up for these examinations was carried out by the staff of the local nursing organization, which maintained the clinic at which most of the examinations were given. The fact that only one-third of the patients delivered received this examination, despite the careful follow-up, indicates that this phase of maternity care needs greater emphasis.

Data regarding postnatal care of patients delivered at home in the small city are too incomplete to justify comment.

The physical and mental isolation of some rural families and their consequent failure to make medical needs known are illustrated by the following extreme instances taken from the nurses' reports:

In visiting a handicapped child, the nurse found a woman who had delivered herself of a baby 3 days before. The welfare officer, who would have provided help, was not asked to do so. The nurse got bedding and supplies through the Red Cross. Nursing care was given for 4 days at the request of the health officer.

In the spring, when the roads became passable, the nurse visited a farm off the main road and up a very steep hill. A woman pregnant 4 months was driving a team of horses in preparation for spring planting; she said she felt well. Her last baby had been born at 7 months; her husband delivered her and she did not see a physician either before or after delivery. The baby was pale and looked ill-nourished but clean. Another child, 2 years of age, appeared to be well-nourished. The 6-year-old child seemed to be mentally retarded and was said by the father to have worms. As the father had been told that tobacco would help to cure this condition the child was chewing tobacco.

County D—
First Mountainous County.

In the first of the two mountainous counties studied maternity care was rarely provided from public funds prior to the coming of the TERA. Some women were delivered without a physician's services, attended by a member of the family, a neighbor, or a midwife. When the TERA medical-care program was first adopted some town boards were unwilling to give medical relief, and conflict frequently arose between the board and the town welfare officer concerning authorization for care.

During the period of the study 150 women received help from public funds in the form of maternity care—63 in the rural sections and 87 in the city (table 2, p. 22). In the rural area the problem of providing medical care was made more serious by the remoteness and isolation of some of the population and by the unequal distribution of medical services. In some sections women requested care directly from the

physicians, who then took the initiative in bringing the needs of the patients to the attention of the relief officials and in recommending hospitalization or special nursing care for women needing such services. The decision as to home or hospital delivery was made on the physician's recommendation. Home deliveries were common in the rural areas; only 13 of the 56 deliveries [35] took place in the hospital (table 17). Most of the patients living in sections distant from hospitals preferred home deliveries. One physician usually paid a special visit to these patients before delivery in the company of the work-relief nurse.

TABLE 17.—*County D: Number of months of medical care prior to delivery by place of delivery and attendant; women receiving maternity care at public expense*

Area, and number of months of care prior to dellvery	Maternity cases		
	Total	Place of delivery and attendant	
		Hospital	Home—attended by physician
Total	[1] 132	[2] 61	71
Care received	99	37	62
5 to 8 months	9	2	7
2 to 4 months	28	10	18
1 month or less	25	7	18
Months not reported	37	18	19
No care received	15	7	8
No report on care received	18	17	1
Rural areas	56	13	43
Care received	40	6	34
5 to 8 months	7	1	6
2 to 4 months	17	3	14
1 month or less	12	1	11
Months not reported	4	1	3
No care received	14	6	8
No report on care received	2	1	1
Urban areas	76	48	28
Care received	59	31	28
5 to 8 months	2	1	1
2 to 4 months	11	7	4
1 month or less	13	6	7
Months not reported	33	17	16
No care received	1	1	----
No report on care received	16	16	----

[1] Exclusive of 18 cases resulting in abortion.
[2] Inclusive of 1 case in which delivery was at home and postnatal care in hospital.

Hospitalization for maternity patients was provided in two private hospitals located in the city at a flat rate of $35 for 10 days' stay. Another private hospital, in an adjoining county, was sometimes used for maternity care at a rate of $3 a day plus extras. Patients not

[35] In addition there were 7 abortions, of which 1 was a hospital case (table 2, p. 22).

receiving relief who applied for hospitalization were referred to the investigators, and the county office exercised some supervision over doubtful cases.

State-aided prenatal clinics were held monthly in three townships, and patients living outside the towns were eligible to attend these clinics. Three towns employed nurses to give prenatal and postnatal care and to assist in deliveries at the physician's request. Five work-relief nurses working under the supervision of the district State health officer gave bedside care including assistance at delivery.

No prenatal care at public expense was received by 14 of the 56 patients in the rural section. Twelve received care for 1 month or less prior to delivery; 17 for 2 to 4 months; 7 for a longer period. For the remaining 6 either there was no report or the amount of care was not known (table 17). Records showed some evidence that food allowances for pregnant women were increased, but it was not usual for clients to make their pregnancy known before the last 2 months of the period.

Of the 11 hospital patients for whom data were available, 8 remained in the hospital from 11 to 14 days after delivery and 3 for 6 to 10 days (table 9, p. 38). Among the 30 women delivered at home for whom data were available, 10 received medical postnatal care for less than 6 days, 14 had from 6 to 10 days' care, and the remaining 6 received care for a longer period (table 11, p. 40). Five of these patients were known to have had nursing care at delivery from the work-relief nurses; as the records of one nurse were not available data on the amount of this care were incomplete.

In the city a nurse on the staff of the department of public welfare authorized hospital and home medical care and allotted calls to the salaried physicians and the four work-relief nurses working under her direction. The staff nurse had a good working relationship with the case supervisor and the relief investigators. They all believed, however, that clients asked for medical care unnecessarily. The investigators were aware of the medical problems of their clients and made a definite effort to meet special diet or clothing needs resulting from illness. A number of records noted physicians' recommendations for extra milk or increased food allowances, with corresponding increases in the relief allowances. The relief office had enlisted the aid of a private agency in the city to provide a short period of rest in a convalescent home and housekeeping assistance during pregnancy for two patients for whom the doctor had recommended special consideration.

During part of the period of the study hospital confinements were freely authorized in the two available private hospitals. In February 1936, in an effort to reduce relief costs, women were required to accept the services of one of the salaried physicians, and patients were delivered at home unless the physician recommended hospital

care because of complications. Later it was decided to hospitalize all patients for their first confinements. In addition to the services of the work-relief nurses some nursing service was also supplied by private organizations.

Of the 76 women delivered in this city, 48 were delivered in the hospital.[36] Of these patients, 3 remained in the hospital less than 6 days following delivery; 23, from 6 to 10 days; and 22, from 11 to 14 days (table 9, p. 38). The period of postnatal care was reported for only 8 of the 28 women delivered at home (table 11, p. 40).

For the urban cases it was impossible to separate the data for the period during which hospital confinements were authorized for all patients and for the later period when hospital care was authorized only on the physician's recommendation. The relief personnel believed that they were able to consider the problems of patients sufficiently during the latter period to insure adequate care. The records indicated consideration for individual needs through frequent exchange of information among the city physicians, the nurse in the medical division of the welfare department, and the relief investigators. One physician believed that if hospital care was not authorized freely, there was urgent need for nursing assistance at home deliveries. A hospital executive thought that the change in policy had resulted in last-minute admissions to the hospital among women in the marginal group. His opinion was that these patients realized that if they applied for care early in pregnancy, arrangements would be made for delivery at home, and that they preferred to go without prenatal medical care at public expense and enter the hospital for delivery.

Some of the hospital patients paid small amounts toward their hospital bills. The average cost per case in the city was estimated at $36.22. In the rural section the average estimated cost was $28.24, the lowest figure for the rural areas in any of the six counties.

County E—
Second Mountainous County.

In this county, which was next to the smallest of the six counties in population, 65 maternity patients received help from public funds. Of these cases, 44 were in the rural section of the county, 21 in the city (table 2, p. 22).

Hospitalization for obstetric care was available in four private hospitals, of which two made a flat rate for obstetric cases. Local health workers stated that there was no difficulty in obtaining hospitalization for patients for whom physicians recommended this care. Home deliveries were the rule, however, hospitalization being provided only on the physician's recommendation. In the rural areas medical care was provided entirely by private physicians paid on a fee basis.

[36] In addition there were 11 abortions, all hospital cases (table 2, p. 22).

Physicians' fees for home visits were often $10, because of the isolation of many of the homes; since State reimbursement could be obtained only on a $2 fee, local costs for medical care were high.

The working relationships of the commissioner, the county nurses, and the local physicians appeared to be based on a sympathetic understanding of mutual problems and a desire to supplement one another's services.

During part of the period covered by the study, there were three county nurses in the rural area, cooperating with local health officers and private physicians. Later the number was reduced to two. During most of the period a work-relief nurse was assigned to assist them.

The county commissioner stated that women rarely applied for medical care until a month before delivery was anticipated and that many of the older women had never had a physician's services at confinement until care became available through the TERA. The county nurses encountered a great deal of resistance to prenatal care among the older women who had had several children without medical attention. They told of one woman whom they had persuaded to see a physician before the birth of her sixth child. After that confinement she had six miscarriages, which she attributed to the medical care she received. Although the mother was 46 years of age, had diabetes, and did hard farm work, she was very anxious to have another baby.

In the city some hospitalization was provided in one private hospital, but home deliveries were the rule. Medical care was provided by a salaried physician. Care by private physicians on a reimbursable-fee basis was authorized only in emergencies. Relief and health workers stated that patients expressed great unwillingness to go to the city physician, and accepted his services only after they had made every effort to obtain care from local physicians. No prenatal clinic was available, but relief investigators referred all pregnant women to the nurses in the city health department for prenatal care. Both groups were handicapped by lack of a good working relationship with the physician and a clear understanding of division of responsibility. The three nurses in this department devoted most of their effort to health instruction and gave bedside care only in emergencies. A private agency supported a visiting-nurse service, employing one nurse for bedside care. It also sent graduate nurses to assist at home deliveries at the request of any physician. Patients paid for these services if they were able to; otherwise the fee was met from private funds. Bedside care at a daily rate was rarely authorized by the welfare department.

Of the 43 maternity patients in the rural area, only 5 were delivered in the hospital (table 18). In the city 5 of the 21 patients had hospital deliveries, and 2 of these were emergency cases. The data on pre-

natal and postnatal care of both these groups of patients are very scanty (table 9, p. 38, and table 18). In the city, 16 patients were delivered at home by the city physician; data concerning postnatal care for these patients were not available. For most of the home deliveries in the rural area, also, the extent of postnatal care was not reported (tables 10 and 11, pp. 39 and 40).

TABLE 18.—*County E: Number of months of medical care prior to delivery, by place of delivery and attendant; women receiving maternity care at public expense*

Area, and number of months of care prior to delivery	Maternity cases				
	Total	Place of delivery and attendant			
		Hospital	Home		
			Total	Attended by physician	Attendant not reported
Total	[1] 64	[2] 10	54	53	1
Care received	45	3	42	42	
5 to 8 months	2	2			
2 to 4 months	8	1	7	7	
1 month or less	6		6	6	
Months not reported	29		29	29	
No care received	3	1	2	1	1
No report on care received	16	6	10	10	
Rural areas	43	5	38	37	1
Care received	38	1	37	37	
5 to 8 months	1	1			
2 to 4 months	4		4	4	
1 month or less	4		4	4	
Months not reported	29		29	29	
No care received	1		1		1
No report on care received	4	4			
Urban areas	21	5	16	16	
Care received	7	2	5	5	
5 to 8 months	1	1			
2 to 4 months	4	1	3	3	
1 month or less	2		2	2	
No care received	2	1	1	1	
No report on care received	12	2	10	10	

[1] Exclusive of 1 case resulting in abortion.
[2] Inclusive of 1 case in which delivery was at home and postnatal care in hospital.

As no list of the city physician's visits was available, a list of home deliveries during the period of the study was secured from the records of the local registrar of vital statistics and checked against the central index of the relief agency. In the course of this investigation it was discovered that in addition to the 16 cases delivered by the city physician 19 relief clients were delivered during this period by local physicians who received no payment from public funds. It seemed probable that the relatively large amount of free care given by private physicians in this city resulted from a general dissatisfaction with the

services of the city physician and that the medical needs of the relief group were not being adequately met by the local welfare department under the existing arrangement. This was the only community covered in the study in which the percentage of live births occurring to women cared for at public expense was lower than the percentage of family groups receiving home and work relief (table 4, p. 26). It is also the only community in which information was obtained as to the amount of free care given by private physicians to patients receiving relief.

In the rural section the average cost per case, including estimated costs of nursing care from community agencies, was $34.15 (p. 31). In the urban area the average estimated cost was $24.26, a considerable percentage of which was the estimated cost of community nursing service. This figure is much below that for any of the other communities covered, but the extent of free care furnished by private physicians was probably larger in this than in any of the other communities.

County F—
Suburban County.

The suburban county had the largest population and also the largest number of maternity cases (929) in which care was received through public funds. The great majority of the abortions also occurred here (table 2, p. 22) and represent 16 percent of the total cases with which the study was concerned in this county. Among these 929 cases, 10 maternal deaths occurred; 2 followed live births, 3 followed stillbirths, and 5 followed abortions (table 3, p. 24). The live births to women receiving care at public expense constituted 16 percent of the total live births in the county (table 4, p. 26).

More complete statistical data were available in the suburban county than in any of the others studied, and this fact, together with the large number of cases upon which the averages are based, makes the findings of special interest.

For a year previous to this study an emergency relief bureau had administered home and work relief on a county basis through a large number of local offices which were grouped in districts under qualified case supervisors.

The bureau had been developed under the direction of a capable administrator, experienced in social work. Classes and training courses had been held for investigators, discussion groups had been organized under the case supervisors, and workers had been encouraged to attend classes and extension courses in nearby colleges and professional schools. A nutrition project was maintained for the purpose of assisting families receiving relief in buying food and

preparing properly balanced meals. An effort was made to work out policies for cooperative case work with social agencies in the community; some local offices worked out this problem with considerable success; the records in other offices gave little evidence of joint planning. In general, the records showed a lack of knowledge of health problems of individuals or of consultation with physicians for the purpose of determining social needs related to medical conditions. Few records showed constructive planning to meet problems of disease and disability, although some cases showed excellent teamwork among the home-relief investigators, nutrition workers, physicians, and visiting nurses.

The generalized program for home medical care was carried out almost exclusively by local physicians on a reimbursable-fee basis. The regulations in the Manual of Medical Care were followed closely, and the amount of nonreimbursable medical relief was negligible. During the period of the study two physicians were appointed to the staff of the emergency relief bureau to supervise medical aid. Clinic services were limited to maternal and child health, venereal disease, tuberculosis, and a few specialized services. The local medical society was opposed to any extension of general clinic facilities for the relief and marginal groups. However, various clinic and nursing services were available for maternity care. Although these resources for maternity care were considered by local relief and health workers to be inadequate to meet the needs of the group unable to pay for medical care, the chief problem was one of effective utilization of available resources through community planning and careful working out of agency relationships. Hospital care was authorized by the several administrative units of the department of public welfare (county, town, city, and veterans' relief), and not by the emergency relief bureau.

The local public-health committee conducted prenatal, postnatal, and gynecologic clinics. A free prenatal clinic was supported by public and private funds, and two private hospitals conducted clinics. A mothers' health center was supported by voluntary funds. Hospitalization was supplied by a county hospital and by private hospitals on a fee basis. The maternity service of the general county hospital was limited to a few beds, and for this reason welfare officials had been requested to continue authorizing care in local private hospitals until additional facilities could be provided. Four private hospitals in the county and two across the county line received maternity patients upon authorization from departments of public welfare. Four of these hospitals charged flat maternity rates of $35, $45, $50, and $58 for welfare patients; one charged $4 a day plus $7 for laboratory and delivery-room fee; the other charged $3.50 a day plus $5 for the delivery room.

Relief clients could receive prenatal care from one of the local clinics or from a private physician who was paid on a fee basis. If the patient wished treatment from a private physician, this was authorized by the emergency relief bureau according to the rules and regulations of the Manual of Medical Care.

If a maternity patient wished to be confined in a hospital, she made application to the welfare officer and received authorization for hospital care. Decision as to home or hospital confinement rested largely on the physician's recommendation or the patient's preference. The majority of the records examined gave little evidence of consideration of social factors and consultation by the investigator or case supervisor with the physicians supervising medical care before a decision was reached.

A survey of nursing care made in this county in 1936 disclosed 18 agencies supplying nursing care, including private agencies, village and township boards of health, and the county public-health committee with 5 staff and 14 work-relief nurses. The nursing facilities were unevenly distributed, however, leaving some areas inadequately provided for, and case loads were heavy. The relief bureau paid practical nurses and household workers at a daily rate for home care of clients. In one locality a woman trained in home-nursing classes was often employed, and her work was supervised by the local private nursing organization.

Of the 785 deliveries resulting in live births and stillbirths, 492 occurred in hospitals and 293 took place at home. In 502 of these cases prenatal care was reported (table 19). The fact that public-health work with emphasis on maternity care had been carried on in this county for more than 10 years previous to this study had undoubtedly made the community conscious of the desirability of such care. Furthermore, local relief and health workers expressed the opinion that private physicians did not hesitate to request authorization for medical care from the relief bureau in case the patient was unable to pay. This is borne out by the fact that of the 492 women delivered in hospitals almost one-third (161) received no other aid from public funds.

Of the 502 patients receiving prenatal care, almost half (249) received care for 2 to 4 months prior to delivery; somewhat less than one-third (151), for 1 month or less. Eighty-seven received care for 5 to 8 months, and 1 woman was reported to have had care for 9 months prior to delivery (table 19).

Of the 486 patients for whom length of postnatal hospital care was reported (table 9, p. 38), almost half (239) remained in the hospital from 6 to 10 days after delivery. Another 42 percent received from 11 to 14 days' care, and 36 (7 percent) remained in the hospital 15

days or longer. Only 5 patients had as little as 5 days of hospital care.

TABLE 19.—*County F: Number of months of medical care prior to delivery, by place of delivery and attendant; women receiving maternity care at public expense*

Area, and number of months of care prior to delivery	Maternity cases				
	Total	Place of delivery and attendant			
		Hospital	Home		
			Total	Attended by physician	Attended by midwife
Total	[1] 785	[2] 492	293	292	1
Care received	502	223	279	278	1
5 to 8 months or more	[3] 88	41	47	47	
2 to 4 months	249	97	152	151	1
1 month or less	151	79	72	72	
Months not reported	14	6	8	8	
No care received	4	1	3	3	
No report on care received	279	268	11	11	
Rural areas	608	400	208	207	1
Care received	377	180	197	196	1
5 to 8 months	63	35	28	28	
2 to 4 months	196	79	117	116	1
1 month or less	108	62	46	46	
Months not reported	10	4	6	6	
No care received	4	1	3	3	
No report on care received	227	219	8	8	
Urban areas	177	92	85	85	
Care received	125	43	82	82	
5 to 8 months	[3] 25	6	19	19	
2 to 4 months	53	18	35	35	
1 month or less	43	17	26	26	
Months not reported	4	2	2	2	
No report on care received	52	49	3	3	

[1] Exclusive of 144 cases resulting in abortion.
[2] Inclusive of 4 cases in which delivery was at home and postnatal care in hospital.
[3] Inclusive of 1 woman who reported 9 months of care.

Of the 292 patients delivered at home by a physician, the extent of postnatal care was ascertained for 271 (tables 10 and 11, pp. 39–40). About half of these (137) received 4 to 6 postnatal visits from a physician; another 45 percent (123) received 7 or more visits. Only 11 of the patients received as few as 3 visits. Two-thirds (181) of this group of 271 patients were under a physician's care for 6 to 10 days following delivery. Another 28 percent (77 patients) received postnatal care for 11 days or more, and 13 patients received care for less than 6 days following delivery.

The total public expenditures for maternity care in the suburban county (table 6, p. 28) show a relatively small amount ($7,616) paid for home medical care as compared with the amount ($31,562) paid for

hospital care. Since physicians in this county were, in general, willing to perform home deliveries and the relief bureau did not urge hospital care, it seems likely that the large percentage of hospital deliveries is attributable chiefly to the urbanized character of the area and the long education of the population in public-health work which led the patients to appreciate the advantages of hospital care.

The average cost per case, including estimated contributory costs for clinic and nursing care which were not paid directly from public funds, was $45.18. This figure is a relatively high one when compared with costs in the other counties studied. But, in view of the fact that among the women for whom prenatal care was reported 30 percent had no care until the month before delivery and only 18 percent had prenatal care for 5 months or more, the cost is probably lower than that necessary to provide what may be regarded as adequate care.

Special Considerations in Provision of Care

For six counties of New York State this report has described the operation, so far as it is related to maternity services, of a State-wide program for medical care in the home, conducted under the auspices of local welfare departments with supervision and financial assistance from the State agency. Procedures for hospitalization of maternity patients have been described and the extent of such care tabulated and studied. The scope of the State program was restricted to supplementation of local facilities and services, and the policy adopted involved the continued use of hospitals, clinics, and medical, dental, and nursing services already established in the communities. The varied character of these local resources resulted in wide variation in local practices and in the extent of State participation in the provision and financing of medical care. Nevertheless the study of 1 year's operation in six counties revealed certain common problems demanding further thoughtful consideration.

The most important of these problems are:

1. The difficulties inherent in the authorization of medical, nursing, and hospital care of maternity patients by officials or workers with little or no understanding of medical needs.

2. The method and basis of determining whether delivery should be in the hospital or the home.

3. The problem of meeting hospital costs.

4. The maintenance of a high quality of medical service.

5. The relation of medical and social factors and provision for special needs related to illness.

Authorization of Maternity Care by Welfare Officials.

In the rural areas studied, authorizations for maternity care were issued by nearly 100 local welfare officers under the general supervision of the county commissioners. Supervision of township officials by county officials was in general limited by a regard for traditional town rights and by the inaccessibility of some of the areas during the winter months. These local welfare officers usually had no medical knowledge and no formal training in social work and sometimes had only a limited general education. They worked on a part-time basis and were usually paid a modest sum according to the amount of work demanded of them.

Their attitude toward the welfare work they were doing varied widely. Some made a sincere effort to meet the needs of the families receiving relief; others appeared to grant relief, including medical care, grudgingly and to think that the more unpleasant it was for a person to remain on relief the sooner he would cease to be a charge on public funds. It was natural that the rural welfare officers tended to emphasize cost of services rather than the applicants' needs, in view of their own background, which had taught them the value of a dollar but not the principles of good medical care or social work. Furthermore, their expenditures were audited by the town boards who appointed them, and their appointments depended to some extent on their ability to keep relief costs at a minimum.

There was evidence that the attitude of some welfare officers tended to discourage clients from making early application for prenatal care and that the effectiveness of instruction given by public-health nurses was limited in some instances by the efforts of the welfare officers to curtail relief expenditures. The standards set forth in the Manual of Medical Care were far in advance of the general practice in some communities, and this further complicated the problem.

As the object of public provision for maternity care is to enable mothers to give birth to healthy children normally, with minimum risk to life and health, through the employment of modern medical knowledge and skill, it seems reasonable that authorization for care should be in the hands of individuals who have an understanding and appreciation of the principles of good medical care. Knowledge of the medical need as well as the social situation of patients is essential in granting such authorization and in making the choice between home and hospital care.

The authorization involves, therefore, the determination of medical need, which should be a medical responsibility assumed by a physician, and the determination of eligibility for care at public expense, a responsibility of the government agency authorizing the expenditure of funds. Ideally, final decision regarding authorization of care can best be made by a well-qualified physician on the staff of the agency authorizing care, who has been given responsibility for reviewing the recommendation of the physician attending the patient and of the social worker who is familiar with the social situation. The review of the social worker's recommendation should be made in the light of the patient's medical need.

It is recognized that great difficulties are involved in introducing such procedures in local administrative units that are not large enough to permit effective and economical administration of medical-care programs under the direction of a physician. A practical temporary solution may be to devise means of giving local health and welfare workers increased understanding of the basic principles involved in

the provision of medical care at public expense and of the social and psychological factors related to health that demand consideration in the determination of eligibility.

In all the local administrative units studied, a part-time or full-time health officer who was a qualified physician was available, and it would appear that the services of these health officers might be utilized by the welfare department in an advisory capacity. Explanation of medical needs by these officials would insure earlier and more adequate prenatal care. The welfare official would be able to exercise his function of authorization more satisfactorily if he had the opportunity of periodic consultation with a medical social worker for consideration of policies, review of accepted and rejected cases, and discussion of individual problems. It is possible that eventually a plan might be worked out providing for authorization of care by the welfare officer upon certification of medical need by the local health officer or a medical officer on the staff of the welfare department.[37]

Hospital or Home Care.

Individual consideration of the needs of each patient is fundamental in an adequate medical-care program. It is also a fundamental concept of social case work. This principle is not followed in any plan for maternity care which provides either that all patients are hospitalized automatically or that all are delivered at home.

In some areas included in this study, hospital care at confinement was restricted to women for whom physicians recommended hospitalization because of complications of pregnancy. In one city all patients were hospitalized, and there was no provision for home deliveries for patients cared for at public expense. Such restricted plans inevitably result in situations in which patients attempt to circumvent the system by not making the fact of pregnancy known until delivery is imminent. In the county in which authorization for hospital deliveries was the routine practice there were instances of women wishing to be delivered at home who called the welfare officer to request a physician's services after labor was well under way. In areas that had a rigid policy of home delivery, on the other hand, hospital administrators reported an increase in emergency admissions.

In other communities the choice of home or hospital delivery was made by the patient; in one county authorization for home care was given by the county relief agency and authorization for hospital care by the several town welfare officers. In only one area (County C, City I) was the authorization of home or hospital care at confinement made by the relief director on the basis of the medical recommendation and the social situation.

[37] Provision has since been made in some counties in New York State for the county medical director or consultant to perform the same functions for town welfare departments as for the county department upon the request of the town and upon its agreement to conform to the policies and procedures of the county plan.

The desirability of routine hospitalization for confinement is a matter on which medical opinion is not unanimous. Physicians are agreed, however, that the safety of a delivery is dependent on the quality of the medical and nursing service, including measures taken to protect the patient from infection and to deal with emergency situations, rather than on the locale of the confinement. The recent demand on the part of the public for hospital care at confinement has made heavy demands on hospitals inadequately equipped to serve maternity patients. Minimum requirements for obstetric departments in general hospitals have been formulated by the American Hospital Association, the American College of Surgeons, and other organizations, and hospitals are adapting their physical facilities and the organization of their medical and nursing staffs to comply with the standards that have been set.

An ideal program, which may ultimately be achieved, would include a sufficient number of beds in hospitals with adequate obstetric service to afford safe care for every maternity patient and sufficient funds for the physician's fee, the hospital charge, and prenatal and postnatal nursing service in the home for those unable to obtain medical care for themselves. But while funds are limited and beds in hospitals with adequate obstetric service are not available in sufficient numbers, some choice must be made of the cases to be hospitalized.

This choice should be made on the recommendation of the physician attending the patient, after consideration of the home situation and the adequacy and quality of available resources. It is also recognized that consideration of the total funds available for maternity care will influence the choice to some extent in instances where social rather than medical factors indicate that hospitalization is desirable. For instance, local administrators may be forced, through limitation of funds, to choose between a more liberal policy regarding hospital care at confinement and added provision for prenatal care.

In this connection attention may be directed again to the figures presented in the section on Expenditures From Public Funds (p. 27), which indicate that the average cost of hospital deliveries was significantly higher in all the areas studied than was the average cost of home deliveries, partly, indeed, because complete maternity care was not provided from public funds for home deliveries. The average cost of home deliveries in all these areas was based on direct expenditures from welfare funds, and bedside nursing was provided directly from welfare funds for only a very small number of cases. Prenatal medical care and nursing service were provided for many of these patients by agencies in the community, supported in some instances by appropriations from other public funds and in others by private contributions. The average cost of these home deliveries would be much higher if full provision were made for all costs including nursing service at

delivery and postnatal nursing care—services which are essential in any plan for home care of maternity patients.

An estimate of the real cost of complete and adequate home care should include payment for care by a physician from the time when pregnancy is suspected throughout the prenatal, delivery, and postnatal period; and a minimum of three home visits by a nurse during the prenatal period, nursing care at delivery, and five postnatal nursing visits. The cost of this complete care is estimated at $41, on the basis of the maximum medical fee upon which reimbursement was allowed and the estimated cost of nursing visits used in this study (p. 31). This estimate is exclusive of costs of travel for physician and nurse, necessary supplies and equipment, and continuous nursing care or housekeeping assistance in instances where such care is recommended by the physician.

Meeting Hospital Costs.

During the entire period of operation of the plan providing State aid for medical care in the home, local communities bore the full cost of hospitalization. In table 6 (p. 28) it has been shown that in all but one of the counties as a whole, and in all the urban sections considered separately, the total expenditures for hospital care of maternity patients exceeded those for home care. This is to be expected, although the ratio of costs is undoubtedly influenced by the fact that complete maternity care was not provided directly from public funds for women delivered at home. Seventy-five percent of the total expenditure from State and local welfare funds for maternity care was for hospitalization of maternity patients. These expenditures, as has been pointed out, were a charge on the local funds and in many communities were met with great difficulty. It is questionable how long local welfare districts can continue to carry these charges without assistance. In 1937 the need for financial aid was repeatedly expressed by county commissioners, since exhaustion of local funds and of resources for borrowing was making the problem acute.

Despite the fact that hospital costs were borne entirely by the local unit, no instance was noted of refusal by a welfare official to authorize hospitalization for a maternity patient for whom a physician had recommended hospital care.

Some counties had a very high proportion of home deliveries, and unquestionably a much larger proportion of patients would have benefited by hospital care if greater consideration had been given to factors of crowding and lack of proper facilities in the home, distance from the local doctor, and so forth, in making choice of home or hospital care. It is significant that in the area where decision as to home or hospital care was based on the medical and social needs of the individual patient 43 percent of the women delivered were hospital-

ized, whereas in another county hospitalizing only patients for whom the physician recommended hospital care because of complications 30 percent were hospitalized.

It appears, therefore, that the proportion of hospital deliveries will not be decreased through a more individualized administration. However, in some cases now requiring a hospital stay longer than average, the length of stay and cost of care per patient may be decreased appreciably without impairment of the quality of service through better coordination of facilities for home and hospital care, provision of housekeeping service, and so forth. The average costs for hospital deliveries in the counties studied ranged from about $40 to $59. A fee for physician's services for delivery and postnatal care was included in only a very small number of hospital cases. If such fees were included for patients receiving care in private hospitals and provision made for payment for adequate prenatal care by a physician or at a clinic, and for prenatal nursing care, the cost of a hospital delivery would be between $65 and $70. On the basis of these considerations it appears, therefore, that State aid in hospitalization as well as in home care of maternity patients is essential to the growth and development of a satisfactory program for maternity care.

Maintenance of a High Quality of Medical Service.

The rules and regulations of the Manual of Medical Care included a statement of minimum standards for maternity care which provided for a high quality of service. These standards are given in the appendix to this report. Only physicians and midwives licensed to practice in the State could be authorized to participate in the plan. The manual recommended that local commissioners of public welfare maintain lists of physicians and other licensed professional attendants who had agreed in writing to comply with the rules and regulations in the manual. It was further suggested that when a patient requested the services of a physician not already on an approved list the written authorization to the physician be accompanied by a copy of the rules and regulations and a statement that acceptance of the authorization implied compliance with these rules in giving professional care.

In none of the areas studied was there provision for general professional review of the work of individual physicians. In some communities committees from the local professional organizations gave consideration to cases referred to them by relief workers. The State medical director and his assistants were also available for advice and consultation. In some cases local standards of medical care were raised in this way. There was, however, no checking of medical records by a well-qualified physician on the staff of the authorizing agency as a matter of routine, and standards of care were maintained

only through the employment of properly qualified physicians and through the issuance of the regulations of the Manual of Medical Care.

Payment for services was based on diagnosis and on the number and dates of visits made. The physician, as a rule, received the $25 fee authorized for complete maternity care, including delivery in the home, only if the patient had been under his care since the fifth month of pregnancy. A check might be made of the period of time under care, since dates of the physician's visits were necessary for payment of the bill. No check could be made, however, as to whether the physician had actually made the required complete physical examination of the patient early in pregnancy, including a Wassermann or comparable test (not at that time required by State law), urinalysis, determination of blood pressure; also pelvic measurements and examination at or before the seventh month.

It is recognized that reviewing medical records presents great difficulties. Many physicians do not keep complete records, and few of them have clerical assistance. They are often impatient of such procedures, and insistence on detailed records may result in their refusal to treat relief patients. The fact remains, however, that adequate care, particularly during the prenatal period, cannot be insured without some provision for review of the nature of that care by a physician.

The use of consultant service is an important factor in maintaining high standards of care. The Manual of Medical Care made provision for authorization of the services of consultants at the request of the physician in attendance, the patient, or her family. Lack of recognition by local welfare departments of the qualifications which should be required of consultants and the unavailability of well-qualified specialists in most rural areas made consultation service a difficult problem. Furthermore, the maximum charge for a consultation on which State reimbursement was allowed was $2, the same amount established for the usual home visit. Such provision may be expected to encourage consultation between local physicians and to make it possible for young physicians to secure advice from more experienced general practitioners, but it will not make the services of qualified specialists in obstetric care available on a consultation basis. To accomplish this it is necessary to establish objective standards of training and experience for physicians serving as consultants and to make provision for recognition of the quality of this service in calculating reimbursable charges.

In several areas prenatal clinics were held regularly and visits to a local clinic by arrangements approved by the authorized attending physician were counted as regular prenatal home and office visits. If the dates of such visits were entered on the physician's bill, the

regular flat obstetric fee was allowed. Physicians generally did not avail themselves of this opportunity, however, and it is questionable if this provision was generally understood.

Neither of the two county hospitals providing maternity care operated prenatal clinics, although in one hospital prenatal care was available by the resident staff at the patients' request. Few patients presented themselves for examination, and no records were available concerning the care given. One county and one city had no prenatal clinics. In several areas physicians and hospital administrators spoke of difficulties in exchange of information between clinics and hospitals and expressed a strong feeling that prenatal care should be given by the physician who delivers the patient. Continuity of care by the physician, while desirable, is not always possible, however, and where this cannot be provided great effort should be made to facilitate easy and rapid exchange of information regarding examination and treatment.

Extension of clinic facilities coordinated or associated with hospital service and workable provision for use of consultation services of specialists are important points for consideration in assuring high standards of professional care.

Coordination of Medical and Social Factors.

Physicians who are giving freely of their skill and time in the treatment of patients on relief rolls have a right to expect the relief administration to provide for the special needs of their patients which are related to the medical problem. A physician treating maternity patients should receive cooperation from the relief organization in early referral of cases; assistance in follow-up unless that responsibility is assumed by another organization; provision for enabling patients to receive a liberal diet in all instances, with special needs met upon his recommendation; help in planning confinement care with the assistance of a nurse, if the delivery is to be in the home; and housekeeping service and essential household equipment when necessary. Anxiety and apprehension on the part of the patient often limit the effectiveness of medical care; it is the responsibility of the social worker and the public-health nurse to aid the physician in dealing with these factors.

In rural areas, where relief offices are staffed by incompletely trained social workers with heavy case loads, meeting such needs is a difficult problem. It may be greatly lessened, however, if there is a qualified public-health nurse who serves the area and with whom the relief worker may cooperate. The relief worker cannot provide intelligently for the patient's needs unless she has an understanding of her condition in terms of disability and work capacity, activity limitation, prescribed treatment, and prognosis. She needs to know whether the

pregnant woman is able to do all her own housework, whether she needs special food, and whether the physician has recommended any other special program. The public-health nurse usually can assist the relief worker in these circumstances, and a division of responsibility for various phases of treatment of individual patients can be worked out in conferences between the social worker and the nurse. Conferences with a medical social worker from time to time are necessary for local workers in developing policies for cooperative effort and are helpful in treatment of individual cases, since the medical social worker is especially equipped to advise on social problems connected with health and medical care.

In some of the areas studied the medical needs of clients were effectively explained to relief workers by the county nurses. In one such county, where there was close cooperation between the public-health nurse and the relief-work supervisor, no emergency authorizations for delivery were noted. In another county the nurse and the county commissioner worked well together, and in instances where the patient was unwilling to ask authorization for maternity care from the local welfare officer the nurse took the matter up directly with the commissioner. In one small city the commissioner and the medical social worker at the local hospital worked closely together, and in another city the director of the home-relief bureau and the city hospital superintendent supplemented each other's efforts intelligently and efficiently.

In the areas just mentioned records gave evidence of a recognition of the interrelationship of medical and social factors; the effectiveness of medical treatment was enhanced by the consideration given by relief workers to the special needs of individuals. In the majority of areas, however, there was little indication that the relief investigators understood the health needs of their clients.

The relation between medical and social factors has come to be recognized by most physicians, but medical and social agencies have often been slow to coordinate their efforts. In the public-welfare field medical care for those unable to pay for it has been planned and administered largely by the welfare groups that finance the service. Health departments in general have considered that public health and certain aspects of preventive medicine were within their province and have left to the welfare officials all matters related to curative medicine. At the present time health departments are recognizing that they have a responsibility in relation to the provision of medical care. They are administering services for crippled children in half of the States and are showing willingness to provide consultation services for other types of medical care.

Recognition of the necessity for cooperative effort in the provision of medical care at public expense has been expressed through the work

of a joint committee of the American Hospital Association and the American Public Welfare Association, which has been giving consideration for several years to the subject of hospital care for the needy. In 1937 the two associations officially adopted a statement of general policy concerning the use of tax funds for the care of the needy sick in nongovernmental hospitals.[38] This statement emphasized the fact that a high standard of care of patients is important and is an ultimate economy and urged that public officials appreciate the close relation of hospital service to general medical practice and to public health. In the following year the joint committee presented detailed suggestions for carrying out these policies effectively. In the section concerned with determination of eligibility for care emphasis is placed throughout on the need for conference and joint effort among the agencies and individuals concerned in the provision of care. Recognition is given to the fact that hospital care at public expense should be provided for the marginal group who are otherwise self-supporting. The joint committee recommends that decision as to eligibility for care among this group be reached by qualified persons after investigation and consideration of the medical and social factors involved in individual cases. The recommendations of the joint committee have been approved by both associations.

The American Public Welfare Association has further emphasized the need for development of cooperative relationships between welfare and health departments. A physician was appointed to the staff of the American Public Welfare Association in 1937 to act as consultant on medical care; a few months later several members of the association were asked to serve as a committee on medical care. The first report of this committee,[39] presented in June 1938, stresses the fact that many agencies and groups other than welfare officials are intimately concerned with problems in the administration of medical services. The provision of better medical care for those unable to pay for it themselves is recognized as a common goal of the medical professions and of many national agencies, official and unofficial, the cooperation of which is essential in furthering improvement in the organization and administration of public medical services. The committee recommends that welfare authorities cooperate to the fullest extent with other government departments concerned with public health and medical care in order that overlapping, duplication, and gaps in service may be avoided.

In December 1939 the board of directors of the American Public Welfare Association approved a tentative statement of principles con-

[38] Hospital Care for the Needy: Relations Between Public Authorities and Hospitals. *Hospitals* (Journal of American Hospital Association), Vol. 13, No. 1 (January 1939), pp. 22–29.

[39] Report of the Committee on Medical Care, Annual Meeting, Seattle, Wash., June 1938. American Public Welfare Association, Chicago, June 1938. 48 pp. Mimeographed.

cerning the administration of tax-supported medical care in which these points are developed further.[40] This statement recommends the development of a cooperative relationship whereby the welfare or other department charged by law with providing medical care obtains service or technical supervision through the department of health and pays for it accordingly. It further recommends that the department carrying the major responsibility for tax-supported medical care make official use of the State or local health officer in an advisory capacity by ex officio appointment or otherwise.

An outstanding feature of the New York State plan for medical care was the working out of the program under the direction of a physician from the Department of Health, assigned to the Temporary Emergency Relief Administration for this purpose. This procedure insured close cooperation between the two departments. A medical social worker assisted the medical officer in the administration of the plan. This same physician was later appointed chief medical officer in the State Department of Social Welfare, which assumed the functions and powers of the TERA on July 1, 1937. As he has also been designated consultant in medical care to the State Department of Health, it is anticipated that the two departments will continue their coordinated efforts in the field of medical care for the group unable to provide such service from their own resources.

A supervisor of medical social work has been appointed in the Division of Medical Care of the State Department of Social Welfare, and medical social workers have been placed in the district offices to aid in the administration of medical care. Such workers have been added to the staff of the home-relief bureau in the suburban county covered in the study, and other local offices have made similar appointments.

Recognition on the part of officials administering the State program of the interrelation of medical and social factors is a powerful force which is making itself felt increasingly in the local offices. The formulation of policies and procedures embodying this concept is a gradual process, conditioned by local public opinion and the development of personnel qualified to present this point of view in a manner intelligible and acceptable to local groups. Relief and home medical care remain local administrative problems under the present Public Welfare Law, although the fiscal unit has become the county rather than the town.

In the past few years more frequent contact with State workers has stimulated local relief and health officials to a coordination of their efforts. The findings of this report indicate that in some areas

[40] Organization and Administration of Tax-Supported Medical Care: A Tentative Statement of Essentials and Principles. Committee on Medical Care of American Public Welfare Association, Chicago, 1939. 8 pp. Processed.

the work of local relief and health agencies was well coordinated. In the areas where this had not yet been achieved, officials were well aware of the problem and desired professional advice and help in its solution.

The number of patients receiving aid from public funds for maternity care during the year of the study was impressive, especially in view of the fact that most rural relief officers had developed a sense of responsibility in the provision of maternity care only in the past few years. In some communities, however, there was still evident a general lack of appreciation of the value of prenatal care and postnatal follow-up. The problem of adequate prenatal care was, of course, more difficult of solution in the rural than in the urban communities, because of the isolation of many rural families and their unfamiliarity with relief and clinic procedures. The solution of this calls for still closer working relationships between welfare departments and local health authorities, who should be responsible for providing adequate facilities for prenatal care through clinics and public-health-nursing services. In some instances, even though the value of prenatal care was recognized, women felt great reluctance to receive aid from public funds, associated in their minds with dependency and "shiftlessness," and delayed application in the hope that they might later be able to provide for their own care. This attitude should be recognized in planning for the care of the "medically needy" who are ordinarily self-sustaining but unable to pay for necessary medical care.

The close working relationship between the New York State Departments of Health and Social Welfare offers unusual opportunity for increasing cooperation in plans for maternity care. The introduction of medical-social workers into the local offices of the State Department of Social Welfare provides a means of interpretation of medical problems to relief workers and social problems to health workers and so of active coordination of local programs for medical and social treatment. Constructive planning for more adequate public provision for maternity care may well be the forerunner of constructive planning for more adequate provision of medical care in other fields. The provision of maternity care involves all the administrative techniques and procedures necessary for a program of general medical care. It is a program of which the extent can be accurately predicted, the cost closely estimated, the personnel needs easily budgeted. For these reasons particular interest will attach to further developments in the New York State program for maternity care.

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Recommendations

The following recommendations are offered after consideration of the fundamental problems observed in the administration of maternity care in six counties in New York State. They are presented as suggested means of improving maternity service to individual patients through changes in the procedure of authorization, coordination of the work of health and welfare agencies, and the provision of increased facilities.

1. Authorization of home and hospital care (medical and nursing) should be placed in a single agency or central medical unit, and the decision as to whether the delivery will be in home or in hospital should be based on the medical and social needs of the individual.

2. Authorization for maternity care should be made the responsibility of a physician on the staff of or serving in an advisory capacity to the department authorizing care. Decision should be made after a review of recommendations from the physician attending the patient and from a social worker who is familiar with the social situation.

3. Further consideration should be given to the problems presented by women not in families receiving relief who postpone securing prenatal care or curtail the length of hospital stay or the convalescent period because of inability to meet the costs involved.

4. Emphasis should be placed by the central authorizing agency on continuity of service to the patient. This agency should insist upon the exchange of medical, nursing, and social information among the agencies providing such care. The division authorizing medical care should have close working relationships with all public-health services, nursing agencies, and hospitals in the community, and also with divisions of the welfare department concerned with the meeting of special needs of patients (dietary, clothing, housekeeping assistance, and so forth) which are related to illness.

5. Consultation service of medical social workers should be made available to local welfare and health workers to give assistance in relating the medical and the social aspects of maternity care.

6. State aid should be made available to local government units in the provision of good hospital care to maternity patients on a participating basis similar to the plan for State aid in the provision of home care.

7. Increased provision should be made for prenatal clinics, preferably in connection with hospitals used for maternity care. Emphasis

should be placed upon the laboratory and consultation services which such clinics can offer to local physicians, particularly in the treatment of the medically needy.

8. Increased provision should be made for consultant services by specialists, pediatricians as well as obstetricians, to be readily available for patients in home and hospital.

9. Review of the services of individual physicians treating patients at home and in hospitals should be made by a physician on the staff of the authorizing agency in order that a high quality of medical service may be maintained.

10. Increased provision should be made by official health agencies or under their supervision for maternity nursing services, including nursing assistance to physicians performing home deliveries.

Appendix

Schedule Used in the Study

U. S. Department of Labor
Children's Bureau

MATERNAL CARE STUDY OF NEW YORK RURAL RELIEF CASES

Agent _____ Serial No. _____
Date _____ Case No. _____

I. Identifying information:
1. County _____ 2. Township _____
3. City or village _____
4. Client's name _____ 5. Date of birth _____

II. Social Data:
1. Case opened and closed: a. From _____ to _____
b. From _____ to _____ c. From _____ to _____ d. From _____ to _____
2. Number of members in household: a. Under 18 ____ b. 18 and over _____
3. Total weekly needs _____ 4. Total gross income _____
5. Budget deficit _____ 6. Nationality _____
7. Husband's usual occupation _____
8. Number of children of this mother: a. Born alive and now living _____
b. Born alive and now dead _____ c. Stillborn _____

III. Medical Service Rendered:

	Cost
A. Prenatal care:	
1. Month of pregnancy and No. of visits _ _ _ _ _ _ _ _ _ _ (1 2 3 4 5 6 7 8 9)	_____
2. Complications: Yes _____ No _____	_____
a. Diagnoses and dates of visits	
(1) _____	_____
(2) _____	_____
(3) _____	_____
B. Delivery: Date _____	XXXX
1. At home	
a. By physician _____ b. By midwife _____	_____
c. By other (specify) _____	_____
2. Hospital	
a. Public _____ b. Private _____	_____
3. Maternity home (specify) _____	_____
4. County infirmary (specify) _____	_____
5. Other (specify) _____	_____
C. Postpartum care: Dates of visits _____	_____
D. Final gynecological examination: Yes ___ No ___ Date _____	_____
E. Final status of patient _____	XXXX
F. Final status of child _____	XXXX
G. Total cost of medical service rendered (Total of A–D) _____	_____

TERA Form 277.

AUTHORIZATION, INVOICE AND VOUCHER FOR PROFESSIONAL SERVICES

Work Relief Disability ☐ Home Relief ☐

EMERGENCY RELIEF BUREAU OF _____ City _____ County

Voucher No. _____

AUTHORIZATION: DATE _____, 193__

Relief Order No. _____

TO _____ (Name of Physician, Dentist, Nurse or Institution—Indicate which)

Home Relief Case No. _____

ADDRESS _____ (Street and Number) _____ (City or Town)

Disability No. _____

USE FOR HOME RELIEF

You are hereby authorized to supply medical, dental and/or nursing service within the restrictions and according to the Regulations given in the TERA "Manual of Rules and Regulations Governing Medical Care Provided in the Home to Recipients of Home Relief" to:

USE FOR WORK RELIEF DISABILITY

The bearer, or the patient whose name and address appears immediately below, is an employee of the Work Bureau on Project _____ and alleges that he met with an injury or disability in the course of his employment, on Date _____, 193__ You are hereby authorized to give NECESSARY TREATMENT for a period of _____ days from date hereof to:

FAMILY NAME _____ HEAD OF FAMILY _____

ADDRESS _____ (Street Address or RFD. No. and Name of City or Town) AUTHORIZED BY _____

FOR: (Indicate purpose) _____ TITLE _____

Following statement to be prepared, invoice dated and signed, and affidavit executed, by Professional Attendant:

DATE 193	INDICATE HOME OR OFFICE CALL (*)	PATIENT'S NAME	AGE	SEX	DIAGNOSIS	SERVICES RENDERED	(**) STATUS	CHARGES
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)

(*) Use symbol "H" for home visit and "O" for office visit

(**) C—CURED T—NEEDS FURTHER TREATMENT H—HOSPITALIZED (name and date as shown) _____ D—DEAD _____ 193__

NAME OF HOSPITAL _____ Date _____ 193__

TOTAL

DATE INVOICE PREPARED: _____, 193__

NOTE (to physician, dentist, nurse or hospital): Enter on the original and duplicate yellow copy of this form the information called for above in columns 1 to 9, specify date invoice is prepared, sign under "received payment," execute affidavit on both copies, and send to local relief headquarters. Keep the triplicate copy for your records.

RECEIVED PAYMENT:

STATE OF NEW YORK } ss.:
_____ County }

_____ being duly sworn says that he actually resides at _____; that the services rendered or charged in the above bill or account were actually rendered to the relief case named herein residing in _____ (City or County) on the order of _____ (Name and Title of Authorizing Officer) at the dates and for the prices herein named, which are just and reasonable for the services rendered; that said bill or account is just and true; that there are no Federal or New York State Taxes included and that there is due hereon $_____ and no part of same has been paid

Subscribed and sworn to before me this _____ day of _____ 193__

_____ Signature

_____ Notary Public or Commissioner of Deeds

(PROFESSIONAL ATTENDANT—DO NOT WRITE BELOW THIS LINE)

(LEAVE BLANK)

ACCOUNTING CLASSIFICATION	
Charge	Amount

(THIS SPACE FOR LOCAL ACCOUNTING OFFICE)

Account Verified; Correct for—

(Signature) _____

I certify that the records of this office show that the services covered by this voucher were rendered, and that the prices charged are in conformity with the authorized scale.

Certified for $_____

_____ Accounting Officer

TERA

Paid by the _____ (Title of Fiscal Officer) _____ (Local Governmental Unit) with Check No _____

Dated _____ For _____ (Amount) Drawn on the _____ (Name of Bank) of _____ (City)

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IV. Nursing Care:		
A. Prenatal instruction: Yes ____ No ____		XXXX
1. Month of pregnancy and No. of visits	1 2 3 4 5 6 7 8 9	
a. Work Relief Project		
b. Public Health Nurse		
(1) State Department of Health		
(2) County		
(3) Visiting Nurse Association		
(a) No charge to D. P. W.		XXXX
(b) D. P. W. pays		
(4) Other private agency (specify)		
B. Bedside nursing care:		
1. ____	Delivery / Postpartum	
a. Work Relief Project		
b. Public Health Nurse		
(1) State Department of Health		
(2) County		
(3) Visiting Nursing Association		
(a) No charge to D. P. W.		XXXX
(b) D. P. W. pays		
(4) Other private agency (specify)		
c. Graduate trained		
d. Practical		
C. Total cost of nursing care (Total of A and B)		
V. Total Cost of Medical Service and Nursing Care (Total of III–G and IV–C)		
VI. Comments:		

Excerpts From Temporary Emergency Relief Administration Manual of Medical Care

Rules and Regulations Governing Obstetric Care (Regulation 4) and (in part) Schedule of Reimbursable Charges (Regulation 9):

Regulation 4. **Obstetrical Care.** *Item 1. Scope.* Authorization for obstetrical service in the home [11] shall include: prenatal care, delivery in the home, and postnatal care; and a requirement that, as far as possible, such obstetrical service shall conform, both in frequency of visits and in quality of care, at least to the standards of maternity care adopted by the regional consultants in obstetrics of the New York State Department of Health.

Item 2. Not emergency service. Maternity care should not be considered an emergency service to be authorized late in pregnancy. Local welfare and health officials, public-health nurses, social workers, family physicians, and families on home relief should cooperate to the end that continuous medical supervision should begin for every expectant mother as soon as pregnancy is suspected.

Item 3. Minimum standards. The following standards of maternity care shall be maintained.

a. Prenatal care shall, wherever possible, conform to the following minimum requirements: 1. First visit at or prior to the fifth month of pregnancy. This first visit should include: histories of previous pregnancies and labors; determination of expected date of confinement; and instruction in the hygiene of pregnancy. 2. A general physical examination as early in pregnancy as possible, with special attention directed to determination of blood pressure, urinalysis, heart, lungs and kidneys, general nutrition, and a blood Wassermann or comparable test. 3. Pelvic measurements and examination at or before the seventh month. 4. Visits at least monthly until the ninth month and weekly thereafter, with urinalysis, blood-pressure determination, and abdominal examination made at each visit. 5. Treatment as needed for ordinary disturbances incident to pregnancy. 6. Social service or visiting-nursing service adequate to insure the patient's cooperation with the attending physician and prenatal clinic.

b. Delivery in the home shall include, in addition to obstetrical attendance for the mother, treatment for the infant as needed, including the administration of prophylaxis, as required by law,[12] to prevent blindness.

c. Postnatal or postpartum care shall include care for both mother and infant as often as may be needed, and bedside visits should be made at least on the first, third, and fifth days after delivery. Authorization for obstetrical care shall include provision for a final gynecologic examination of the mother about six weeks after delivery or before she resumes usual activities.

Item 4. Restrictions and precautions. Due caution shall be exercised that authorization for delivery in the home does not involve undue risk to a patient for whom hospital care may be imperative. The judgment of the attending physician shall be a decisive factor in issuing such an authorization. The physician authorized to attend the confinement in the home shall be responsible for certifying to the local commissioner of public welfare, that, in his professional judgment, delivery in the home will be safe. In those cases where it is the professional opinion of the attending physician that confinement in the home will be hazardous he should notify the local commissioner of public welfare immediately, in order that hospitalization may be authorized in accordance with the provisions of Article X, sections 83 and 85, of the Public Welfare Law. However, expenditures for such authorized hospitalization and hospital care shall not be eligible for reimbursement by the Administration.

Item 5. Complications of pregnancy. Authorization for obstetrical care in the home shall include the items of maternity care specified in the preceding paragraphs. Where complications and/or intercurrent illnesses arise in the course of pregnancy and/or the puerperium and require medical care in addition to that outlined above, the attending physician may request, giving full reasons, addi-

[11] Written authorization for obstetrical care shall be requested and issued within 48 hours of the date of the first prenatal visit.

[12] See Penal Law, § 482, subd. 3, and the State Sanitary Code, Chapter II, Regulation 12, "Precautions to be observed for the prevention of ophthalmia neonatorum."

tional written authorization for giving supplementary care. Reimbursement may be granted by the Administration on the basis of regular home and/or office visits for medical care given under such additional authorization. Some of the complications of pregnancy which may justify additional authorization and reimbursement are: any acute intercurrent infection; pernicious vomiting of pregnancy; uterine hemorrhage; eclampsia, pre-eclampsia and/or any toxemia of pregnancy; and threatened miscarriage.

Item 6. Miscarriage, etc. When pregnancy is terminated prior to the full term, a pro rata allowance may be reimbursable on the basis of the authorized home and/or office visits actually made: Provided, that in case of any early miscarriage (prior to the sixth month of gestation), where a dilatation and curettage is performed, or care is given for any miscarriage at or after the sixth month, an extra allowance may be granted for such service. The total allowance, as a basis for reimbursement, for all such authorized care where the pregnancy is terminated prior to the full term, shall not exceed the allowance made for authorized complete obstetrical care of a normal confinement in the home.

Item 7. Prenatal clinic. Prenatal care given in a local clinic by arrangements approved by the authorized attending physician shall count for regular prenatal home and office visits, and, if the dates of visits to the clinic are entered in the physician's bill, the regular flat obstetrical fee may be allowed as the basis for reimbursement.

Item 8. Emergency hospitalization. a. When, in the course of a delivery in the home, complications arise, during the *second* stage of labor, which make transfer to a hospital imperative, and such delivery is subsequently performed by the authorized attending physician or by another physician, reimbursement may be allowed for payments to the physician originally authorized to attend the confinement in the home, on the basis of a sliding scale, up to 80 per cent of the flat obstetrical fee, depending upon the adequacy of prenatal care given.

b. In certain cases, for whom delivery in the home was originally authorized, but for whom hospitalization was ordered prior to the onset of labor, allowance may be made for the prenatal and postpartum care actually given, on the basis of the regular home or office charges for each visit.

Item 9. Major obstetrical operations. To safeguard the lives of both mother and child major obstetrical operations shall not be undertaken in the home, except where there are no hospital facilities within a reasonable distance. Wherever possible, hospitalization should be authorized locally,[14] for such obstetrical operations as mid or high forceps application, internal podalic version with or without subsequent extraction, Cesarean operation, and the introduction of a Voorhees bag.

Item 10. Obstetrical nursing. Bedside nursing care, as an adjunct to the obstetrical service, is provided in many communities through local public-health nurses employed on work relief. As a supplement to the existing community services, bedside nursing care for expectant mothers and young infants, may be authorized on an individual basis, at the request of the attending physician.

Item 11. Care by midwife. Whenever an expectant mother eligible for home relief requests the attendance of a licensed midwife at her confinement, such service may be authorized, and arrangements should be made for adequate prenatal and postnatal care through existing community services. If there is doubt about the normal progress of pregnancy or delivery, the patient should be transferred immediately to a physician or to a hospital. Authorized obstetrical service provided by a licensed midwife may be eligible for reimbursement by the Administration on the basis of not to exceed one-half of the fee paid to a physician for the same type of service.

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Regulation 9. **Schedule of reimbursable charges.** *Introduction. a.* It is realized by the Administration that with the funds available, it is impossible to compensate fully the physician, dentist, or nurse for his or her professional services. The following schedule of charges, therefore, should not be considered as complete compensation for services rendered, but rather as a maximum basis for reimbursement, with due consideration for the conservation of relief funds to the mutual benefit of the patient, the professional attendant, and the taxpayer.

The following schedule of reimbursable charges was prepared following a conference, in Albany, N. Y., on April 16, 1934, between authorized representatives of the Medical and Dental Societies of the State of New York, the Administration, and the State Commissioner of Health.

[14] Under §85 of the Public Welfare Law, see Chapter III, Section C.

b. The charges listed are hereby established by the Administration as the maximum eligible for reimbursement, under these Rules and Regulations. However, no statement in these regulations shall be construed to prevent a local commissioner of public welfare from making additional payments, for specified services, from local funds;[38] or from making payment at less than the maximum charges stated in these regulations, where the local professional organization has agreed to the authorization of specified services at a lower rate.

Section A. *Medical Care.* (**Personal Services.**) The services of a physician authorized with a view to reimbursement by the Administration, shall be subject to the restrictions imposed by these Rules and Regulations, and expenditures for such services shall be eligible for reimbursement at not to exceed the following schedule of charges.

Item 1. Home visit. Authorized home visits, subject to the restrictions imposed by Section D, page 11, and Regulations 1, 2,[39] and 3, above shall be reimbursable at a rate per visit not to exceed $2.00

Item 2. Office visit. Authorized office visits, subject to the restrictions stated for *Item 1*, above, shall be reimbursable at a rate per visit not to exceed 1.00

Item 3. Obstetrical care. Authorized obstetrical care in the home, including necessary prenatal care, delivery in the home, and postnatal care, subject to the general restrictions and requirements imposed by these Rules and Regulations and the specific requirements of Regulation 4, above, shall be eligible for reimbursement:

a. For the services of a physician, on the basis of an all-inclusive flat rate which shall not exceed 25.00

or,

b. For the services of a physician, on the basis of a flat rate for delivery in the home and necessary postnatal and postpartum care at not to exceed 15.00

and prenatal care at a rate not to exceed $1.00 per visit, with a maximum for such prenatal care at a rate not to exceed 10.00

The total charge, under this plan, for prenatal, delivery, and postpartum care, not to exceed, as above 25.00

c. For the services of a midwife, subject to the requirements of *Item 2*, *c*, Section D and *Item 11*, of Regulation 4, above, on the basis of a rate not to exceed 12.50

d. For authorized obstetrical services not covered above, see Regulation 4, *Items 5*, *6*, and *8*.

[38] Under § 83, of the Public Welfare Law, see Chapter III.
[39] Note especially *Item 6*. Also, mileage is not reimbursable.

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